No. 92-893

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY and CONSOLIDATED GROUP, INC.,

Petitioners,

v.

RICHARD FUGARINO, JO MARIE FUGARINO, and MARC A. FUGARINO,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether employers covered under the same ERISA plan as their employees are "participants" or "beneficiaries" in that plan, and are therefore precluded by ERISA's exclusive federal scheme from asserting state law claims for benefits under that plan.

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Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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PETITION FOR WRIT OF CERTIORARI

Hartford Life and Accident Insurance Company ("Hartford") and Consolidated Group, Inc. ("Consolidated Group")* respectfully petition this Court for a

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* All parties to the proceeding below are listed in the caption to this petition. Hartford Life and Accident Insurance Co. is wholly owned by Hartford Accident and Indemnity Co. Its only partially-owned subsidiary is International Corporate Marketing Group, Inc. Consolidated Group, Inc., has no parent companies or subsidiaries (other than wholly-owned subsidiaries) to be disclosed under Sup. Ct. R. 29.1.

writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

The Sixth Circuit's decision holds that employers (sole proprietors, partners, and corporate owners) covered in the same ERISA plans as their employees are not "participants" or "beneficiaries" entitled to seek plan benefits under ERISA, and yet are entitled to seek inconsistent remedies under state law for the same plan benefits. This decision is based upon a fundamental misunderstanding of ERISA and the policies of Congress that underlie it, is at odds with the holdings of other circuits, and will create confusion, uncertainty, and unnecessary litigation in the administration of ERISA plans.

OPINIONS AND ORDERS BELOW

The opinion of the Court of Appeals, filed July 8, 1992, is reported at 969 F.2d 178 and is reproduced in Appendix ("App.") A at 1a-15a. The order of the Court of Appeals denying rehearing en banc, filed August 24, 1992, is unreported and is reproduced in App. B at 16a-17a. The opinion of the District Court, filed June 4, 1991, is unreported and is reproduced in App. C at 18a-25a.

JURISDICTION

This action was originally filed in the Court of Common Pleas of Summit County, Ohio, and was removed to the United States District Court for the Northern District of Ohio pursuant to 28 U.S.C. § 1441. The District Court had jurisdiction over this action under 28 U.S.C. § 1331 and section 502(e)(1) of the Employee Retirement Income Security Act of 1974 ("ER-

ISA"), 29 U.S.C. § 1132(e)(1). The jurisdiction of the Court of Appeals was based on 28 U.S.C. § 1291. The Court of Appeals denied rehearing en banc by order dated August 24, 1992, and this Petition is being filed within the 90-day period following entry of that order provided by Sup. Ct. R. 13.1, 13.3, as extended by Sup. Ct. R. 30.1. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

This case involves sections 3(6)-(8) and 514(a) of ERISA, 29 U.S.C. §§ 1002(6)-(8), 1144(a), which are set out verbatim in App. D at 26a.

STATEMENT OF THE CASE

A. Statement of Facts

This case involves state law compensatory and punitive damage claims under an ERISA-covered health plan provided by The Glens Restaurant to Richard Fugarino, the sole proprietor of the restaurant, his employees, and their respective dependents. Hartford issued a health insurance policy to a multiple employer trust administered by Consolidated Group in which the restaurant participated, resulting in coverage for the employer and his employees. App. A at 1a-2a; App. C at 18a-19a, 23a-24a.

In 1988, a severe automobile accident left Richard Fugarino's son, Marc Fugarino, a paraplegic. Subsequently, a dispute arose in processing claims for medical expenses relating to the accident. In February 1989, an action was filed in state court seeking compensatory and punitive damages for alleged bad faith in handling both the Fugarino claims and various

other restaurant employee claims. App. A at 2a; App. C at 19a.[1]

B. Decisions of the Courts Below

On March 20, 1989, the case was removed to federal court pursuant to 28 U.S.C. § 1441. App. A at 4a. Hartford filed a motion to dismiss asserting, among other things, that the plaintiffs' claims were preempted by ERISA. *Id.* On June 4, 1991, the United States District Court for the Northern District of Ohio granted Hartford's motion to dismiss. Relying on this Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), the District Court held that (1) the health insurance plan was an "employee welfare benefit plan" governed by ERISA, App. C at 22a-23a, and (2) the plaintiffs were "participants" and "beneficiaries" of the plan within the meaning of ERISA whose state law claims were preempted. App. C at 25a.

On appeal, the United States Court of Appeals for the Sixth Circuit agreed that the plaintiffs' coverage was a "plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits . . . ." App. A at 7a-9a (quoting ERISA § 3(3), 29 U.S.C. § 1002(3)). However, despite finding that Fugarino's medical coverage was an ERISA plan, and despite the uncontroverted evidence that Fugarino participated in and received benefits from that ERISA plan,

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[1] Claims concerning medical bills for Marc Fugarino and the restaurant employees were settled and dismissed. App. A at 3a; App. C at 19a.

the Court of Appeals held that the Fugarinos were not "participants" or "beneficiaries" under ERISA and that their benefit claims were not governed by ERISA. App. A at 12a-13a.

The court reached the latter conclusion by focusing on a Department of Labor regulation stating that plans covering employers *only* are not ERISA-governed "employee benefit plans." App. A at 12a (citing 29 C.F.R. § 2510.3-3(b)).[2] This regulation adds that an individual who wholly owns a trade or business (incorporated or unincorporated) is not considered an "employee" with respect to that trade or business. *Id.* (citing 29 C.F.R. § 2510.3-3(c)(1)). Although the regulation states that it defines "employee" only "[f]or purposes of this section" (i.e., for purposes of determining if an employee benefit plan subject to ERISA has been created), the court below applied that definition out of its explicit context to limit the meaning of "participant" and "beneficiary" in unrelated sections of ERISA, which use the term "employee" in describing those individuals entitled to pursue remedies under all of Title I of ERISA. ERISA § 3(7)-(8), 29 U.S.C. § 1002(7)-(8).

Applying this reasoning, the court below held that an individual who is not an "employee" within the narrow meaning of the regulation cannot be a "participant" or "beneficiary" with standing to pursue ERISA benefit actions. App. A at 12a-13a; *see* ERISA § 502(a), 29 U.S.C. § 1132(a) (ERISA standing pro-

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[2] This regulation, of course, is not directly applicable in this case because the plan sponsored and administered by the restaurant did cover common law employees of the restaurant as well as the restaurant's owner. *See supra* p. 3.

vision); ERISA § 3(7)-(8), 29 U.S.C. § 1002(7)-(8) (definitions of "participant" and "beneficiary" under ERISA). Thus, because Richard Fugarino was a sole proprietor, the court held that he and his dependents could not be "participants" or "beneficiaries" entitled to pursue a benefit remedy under ERISA. App. A at 13a.

Since the Fugarinos had no standing to seek ERISA remedies for ERISA plan benefits, the court concluded that they must be free to pursue non-ERISA remedies available under state tort laws governing insurance contracts. *Id.* At the same time, other employees of the restaurant, who were clearly "participants" under ERISA, were preempted from pursuing non-ERISA remedies. *Id.*

REASONS FOR GRANTING THE WRIT

This case involves an issue at the very heart of ERISA's regulatory purpose: the fulfillment of plan benefit promises. In reviewing the claims for ERISA plan benefits in this case, the court below correctly recognized that the plan was an "employee benefit plan" subject to ERISA. Moreover, the court allowed the plaintiffs to obtain benefits from a plan in which it held the plaintiffs were not "participants" or "beneficiaries." However, the court held that the plaintiffs could not sue for these benefits under ERISA, but it allowed them to pursue non-ERISA state law claims for those ERISA benefits. In effect, the court bifurcated a single plan into an employee benefit plan governed by ERISA, and an insurance contract governed by state law.

The court's decision reflects a fundamental misunderstanding of ERISA, and conflicts with decisions

of this Court and other state and federal courts. In passing ERISA, Congress made clear that all employee benefit plans are subject to *exclusive federal regulation*. Thus, once a plan comes under ERISA's regulatory umbrella, as in this case, ERISA's basic purpose requires that its exclusive benefit enforcement mechanism be available for all benefits promised under the plan to all covered individuals. Otherwise, ERISA's mission of fully protecting plan benefit promises, and forbidding conflicting state regulation, would fail.

The court's decision is at odds with numerous other decisions holding that employer participants may pursue remedies for ERISA plan benefits under federal law, and not under state law. Moreover, in subjecting such plans to the added cost and administrative burden of dual regulation, the decision creates confusion and uncertainty for ERISA plan sponsors and administrators. Accordingly, the Court should grant certiorari to avoid a grievous and troublesome interpretation of ERISA that is inconsistent with the decisions of other federal courts.

A. The Court Below Fundamentally Erred in Determining That Sole Proprietors, Partners, and Corporate Owners Cannot Be "Participants" in ERISA Plans When They Are Specifically Covered by Such Plans

The fundamental underpinning of the Sixth Circuit's decision is its conclusion that sole proprietors, partners, and corporate owners cannot be "participants" or "beneficiaries" for purposes of ERISA, because they are not "employees" within the meaning of the relevant ERISA definition. That conclusion rests on a misinterpretation of ERISA's basic provisions and a misunderstanding of their purpose.

As this Court noted in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), ERISA is a "comprehensive and reticulated statute" designed to ensure the fulfillment of benefit promises. *Id.* at 510 (quoting *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980)). It achieves this goal by delineating an exclusive federal mechanism for the enforcement of benefit promises made by ERISA plans. *Id.* at 523; *see* ERISA § 502, 29 U.S.C.§ 1132 (ERISA enforcement provisions).

Unfortunately, the terms used in ERISA to describe the scope of its benefit remedies have caused some confusion in implementation. *Nationwide Mutual Insurance Co. v. Darden*, 112 S. Ct. 1344, 1348 (1992) ("ERISA's nominal definition of 'employee' . . . is completely circular and explains nothing"). The definition of these terms, therefore, must be informed by their context. If Congress intended ERISA to provide an *exclusive* mechanism to enforce benefit promises, it must also have intended that federal mechanism to apply to all individuals who are entitled to plan benefits. Thus, as the Department of Labor has stated,[3] the provisions of ERISA, including those at issue in this case, must be interpreted "liberally" in accordance with "the protective purposes of ERISA." Department of Labor, Advisory Opinion No. 77-75A (Sept. 21, 1977) (available on LEXIS, 1977 ERISA LEXIS 14).

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[3] The Department of Labor is the federal agency given authority by Congress to interpret and enforce Title I of ERISA. *See* ERISA § 505, 29 U.S.C. § 1135 (authority to promulgate appropriate regulations); ERISA § 502, 29 U.S.C. § 1132 (enforcement authority).

In accordance with this intent, the terms "participant" and "beneficiary," which define the class of individuals who may sue for ERISA plan benefits, *see* ERISA § 502(a), 29 U.S.C. § 1132(a), must encompass all individuals who are entitled to enforce benefit promises under those plans. *See* Letter from Robert J. Doyle, Director of Regulations and Interpretations, Department of Labor, to Susan Katz Hoffman, at 2 (July 31, 1992) (attached as App. E). This is the only interpretation consistent with ERISA's underlying purposes, as well as its specific provisions.[4]

The court below ignored these controlling ERISA doctrines by narrowly interpreting the terms "participant" and "beneficiary" to exclude employer participants from the same federal remedy that protects their employees covered under the same ERISA plan. Moreover, the court compounded its error by allowing such employers to sue for benefits under state law, directly contravening this Court's admonition that regulation of employee benefit plans is "exclusively a federal concern." *Alessi*, 451 U.S. at 523.

In reaching its conclusion, the court relied on a Department of Labor regulation, which states in full:

Employees. For purposes of this section:

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[4] *See, e.g.*, ERISA § 403(b)(3)(A), 29 U.S.C. § 1103(b)(3)(A) (exempting certain custodial accounts from ERISA's trust requirement when "some or all of the *participants* are [self-employed individuals]") (emphasis added); ERISA § 4001(b), 29 U.S.C. § 1301(b) (sole proprietors and partners treated as being employed by themselves); ERISA § 4022(b)(5), 29 U.S.C. § 1322(b)(5) (limiting, but not excluding, the coverage of "substantial owners" participating in plans maintained by unincorporated trades or businesses under the benefit guarantee program of ERISA Title IV).

> (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and
>
> (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

29 C.F.R. § 2510.3-3(c). In quoting this regulation, however, the court omitted any reference to its crucial introductory words: "For purposes of *this section* . . . ." 29 C.F.R. § 2510.3-3(c) (emphasis added). A preceding subsection of the regulation clarifies exactly what these "purposes" are:

> *This section* clarifies the definition in *section 3(3)* [of ERISA] of the term "employee benefit plan" for purposes of Title I of [ERISA] and this chapter.

29 C.F.R. § 2510.3-3(a) (emphasis added).

A limiting definition of "employee" for the purposes of section 3(3) was necessary because of the ERISA requirement that a plan covering *no* employees is not an "employee benefit plan," and therefore is not within the scope of ERISA. 29 C.F.R. § 2510.3-3(b). However, while the regulation is clearly relevant to the definition of "employee benefit plan" in *section 3(3)* of ERISA,[5] it just as clearly does not define "employee" for other purposes, including the mean-

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[5] This threshold issue had already been resolved by the court in favor of ERISA coverage, since the plan did cover common law employees as well as their employer. *See supra* pp. 4-5.

ings of "participant" and "beneficiary" in *sections 3(7) and 3(8)*. But these are precisely the sections to which the court below erroneously applied the regulation.

The error of the court's rationale is most clearly exposed by the preamble accompanying the original promulgation of 29 C.F.R. § 2510.3-3. That preamble makes clear that the word "employee," as it appears in the definition of "participant" in section 3(7), must be interpreted much more broadly than the section 3(3) definition erroneously applied by the Sixth Circuit. In the first proposed version of the Department's regulation, the narrow definition of "employee" quoted above had been applied to all of Title I of ERISA, including sections 3(7) and 3(8) and other provisions defining the scope of ERISA benefit remedies. 40 Fed. Reg. 24,642, 24,643 (June 9, 1975) (proposed 29 C.F.R. § 2510.3-6).

Certain commenters objected to this narrow definition of "employee" because of its effect on the definition of "participant" in section 3(7) of ERISA. 40 Fed. Reg. 34,526, 34,528 (Aug. 15, 1975). These commenters noted that ERISA imposes fiduciary duties requiring, among other things, that all plans be operated "for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A). Thus, if employers were not "participants" under section 3(7), breaches of fiduciary duty would be committed every time an ERISA plan paid benefits to an employer. 40 Fed. Reg. at 34,528. Such violations would arise whether the benefits were paid under state or federal law, because in either event the assets of an ERISA plan would be used to pay benefits to individuals who

are not "participants" or "beneficiaries" under the unduly restrictive interpretation of those terms. To avoid this obviously unacceptable result, and the extension of a restrictive definition of "participant" to all of Title I, the Department declared that "the definition of 'employee' formerly appearing in proposed § 2510.3-6 has been inserted into § 2510.3-3 [its current location] *and restricted in scope to that section.*" *Id.* (emphasis added).[6]

By extending the restrictive concept of "employee" in section 2510.3-3 to determine the definition of "participant" in ERISA § 3(7), the court committed precisely the error the Department of Labor sought to prevent. As a result, it created the very same intolerable consequences described in the regulatory preamble. Accordingly, this Court should grant certiorari to correct the Sixth Circuit's fundamental error and its unintended and unfortunate consequences, described *infra*.[7]

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[6] The court also supported its broad reading of 29 C.F.R. § 2510.3-3(c) by concluding that the exclusion of employers was necessary to fulfill the "fundamental requirement of ERISA . . . that 'the assets of the plan shall never inure to the benefit of any employer.' " App A at 12a (quoting ERISA § 403(c)(1), 29 U.S.C. § 1103(c)(1)). Citation of this provision, however, begs the question whether sole proprietors, partners, and corporate owners, acting in their capacity as plan participants, violate the anti-inurement requirement when they enroll in, pay for, and receive benefits under the terms of an ERISA plan. Moreover, the solution reached by the Sixth Circuit does nothing to rectify any perceived problem in this regard: If the successful pursuit of a claim for benefits from an ERISA plan creates inurement to the benefit of an employer, that problem arises whether the claim is pursued under ERISA or under state law.

[7] *Nationwide Mutual Insurance Co. v. Darden*, 112 S. Ct. 1344

B. The Decision Below Is at Odds With Prior Decisions of This Court and of Other Circuit Courts of Appeal

The Sixth Circuit's erroneous decision conflicts with the ERISA opinions of numerous other courts. In several parallel contexts, these other courts have allowed sole proprietors, partners, and corporate owners to pursue ERISA remedies for benefits owed to them under ERISA plans.

In *Forbau v. Aetna Life Insurance Co.*, No. D-1235 (Tex. Nov. 4, 1992) (available on WESTLAW, 1992 WL 316493 (Tex.)), for example, the Texas Supreme Court expressly found that the dependent of a corporate owner was authorized as "a plan participant or beneficiary to bring an action 'to recover benefits due to [her] under the terms of the plan . . . .' " *Forbau*, slip op., at 3 (quoting ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)). Like the court below, the Texas court noted that the employer's partial payment of premiums on behalf of his employees brought the plan within the ambit of ERISA. *Id.*, slip op., at 2. For the Texas court, however, this determination definitively resolved the issue. Because the plan was governed by ERISA, all claims on behalf of the employer's dependent related to the plan and therefore had to be asserted under ERISA; state law was preempted. *Id.* at 2-3.

(1992), is not to the contrary. In that case, the Court adopted "the general common law of agency" to determine whether an insurance agent covered by an ERISA plan was an "employee," *id.* at 1348 (quoting *Community for Creative Non-Violence v. Reid*, 490 U.S. 730, 751-52 (1989)), only because it was provided with no regulatory guidance to the contrary and no consequences antithetical to ERISA. *Id.* at 1348, 1349 n.5. Both of these factors demand a different result in this case. *See supra* pp. 7-12.

Similarly, the Ninth Circuit, in *Harper v. American Chambers Life Insurance Co.*, 898 F.2d 1432 (9th Cir. 1990), upheld the right of a partner's dependent to pursue benefit remedies under ERISA. The court had no doubt as to the sweeping preemptive effect of ERISA on all state law benefit remedies, including those pursued by partners:

> If [the plan is] an ERISA plan, then only ERISA remedies are potentially available, for ERISA "supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

Id. at 1433.[8] Thus, while the Ninth Circuit found that the partner could not be a "participant" because he was not an "employee" under ERISA § 3(6), 29 U.S.C. § 1002(6), it found that both the partner and his wife were "beneficiaries" because they were persons designated "by a participant, *or by the terms of an employee benefit plan*, who [are] or may become

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[8] This reading finds further support in the Ninth Circuit's subsequent decision in *Kennedy v. Allied Mutual Insurance Co.*, 952 F.2d 262 (9th Cir. 1991), which involved the benefit claims of two corporate owners under a plan that, according to the plaintiffs, also covered non-owner employees. The Ninth Circuit stated:

> The central question of this case in its current status is whether the Plan and the Bond are governed by ERISA. If not governed by ERISA, as concluded by the district court . . . then California law controls.

Id.; *see also id.* at 264 n.2 ("Both parties agree that if the Plan was established and maintained in compliance with ERISA, ERISA law controls this dispute. Conversely, if the Plan does *not* comply with ERISA, California law controls.") (emphasis by the court).

entitled to a benefit thereunder." ERISA § 3(8), 29 U.S.C. § 1002(8) (emphasis added) (quoted in *Harper*, 898 F.2d at 1434). In this way, the court preserved ERISA's exclusive federal regulation of employee benefits, and avoided the unacceptable result of "deprivf ing] [employers] of legal recourse for their claims." *Id.* at 1433.[9]

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[9] On the other hand, at least three circuit courts, in addition to the court below, have held that employers are not "participants" entitled to maintain actions under ERISA to recover plan benefits. *Kwatcher v. Massachusetts Service Employees Pension Fund*, 879 F.2d 957, 964 (1st Cir. 1989); *Giardono v. Jones*, 867 F.2d 409, 412 (7th Cir. 1989); *Peckham v. Board of Trustees*, 653 F.2d 424, 427-28 (10th Cir. 1981). All of these decisions, however, involved so-called "Taft-Hartley plans" jointly administered by union and management trustees. *See Kwatcher*, 879 F.2d at 958 n.2; *Giardono*, 867 F.2d at 411; *Peckham*, 653 F.2d at 425. Such plans are subject to independent requirements under section 302 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 186, which have been interpreted to bar the participation of employers in such plans. *See Aitken v. IP & GCU-Employer Retirement Fund*, 604 F.2d 1261, 1265 (9th Cir. 1979) (citing cases). Although the courts in *Kwatcher*, *Giardono*, and *Peckham* relied in large part on an ERISA-based rationale similar to that of the court below, thus establishing a circuit split that extends beyond the Sixth Circuit, the results in these cases could be sustained through application of the independent requirements of the LMRA, which are not at issue in this case.

At the district court level, at least one court has held, outside the Taft-Hartley plan context, that partners in a law firm are not "participants" or "beneficiaries" entitled to pursue a benefit remedy under ERISA, although that court did not decide whether the partners could pursue a parallel remedy under state law. *Pitre v. Louisiana Health Service & Indemnity Co.*, 122 F.R.D. 497 (W.D. La. 1988).

Numerous other decisions provide further support for a strict dichotomy between ERISA and non-ERISA plans. With respect to the former, all benefit remedies (including those of employers) are governed by ERISA. *See, e.g., Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991) (benefit plans with only one employee participant, and involving ERISA-covered benefits, were ERISA plans, and state law actions seeking plan benefits were therefore preempted by ERISA). With respect to non-ERISA plans, on the other hand, state law benefit claims may be pursued. ERISA § 514(a), 29 U.S.C. § 1144(a) (preemption applies only to laws that relate to employee benefit plans governed by ERISA); *see, e.g., Schwartz v. Gordon*, 761 F.2d 864 (2d Cir. 1985) (ERISA remedies not available for Keogh plan falling outside of ERISA's "employee benefit plan" definition).

The court below ignored the principles established by these decisions. The court had no trouble concluding that the plan met the definition of an ERISA-covered employee welfare benefit plan. App. A at 7a-9a. However, the court disregarded the logical consequence of finding an ERISA plan, and instead invented a new doctrine incompatible with the holdings of these other courts. It held that an ERISA plan covering both employers and their employees results in preemption of employees', but not their employers', state law benefit remedies:

> In order for an individual to bring an action to recover benefits owed under an ERISA plan, the individual must be a "participant" or beneficiary of the plan; if the plaintiff is not a "participant" or "beneficiary," he may sue under and seek the broader relief pro-

> vided by state tort law. However, ERISA regulation applied to the employees . . . who participate in the group health insurance coverage.

Id. at 13a (citation omitted).[10] In reaching this conclusion, the court ignored the circuit court decisions above, and relied instead on dictum from a single district court decision. *See Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 568 (E.D. Cal. 1988) (cited in App. A at 13a).[11]

Thus, the Sixth Circuit's decision, which allows employers to pursue actions for ERISA plan benefits

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[10] The obvious flaw in the court's reasoning is that it asks the wrong question: whether the plaintiffs have a certain *remedy* under ERISA, rather than whether the remedy that is sought "*relate*[*s*] *to*" an ERISA plan. As this Court noted in *Pilot Life*, Congress made careful "policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme" established in ERISA. *Pilot Life*, 481 U.S. at 54. Any preemption inquiry that would allow state law remedies to proceed based solely on the absence of parallel remedies under ERISA, regardless of whether such remedies "relate to" employee benefit plans, would upset the policy choices that Congress made. Of course, a proper understanding of ERISA would allow a remedy in this case, since employers would be "participants" entitled to seek benefits under ERISA. *See supra* pp. 7-12.

[11] The passage from *Dodd* cited by the Sixth Circuit was part of a preliminary framing of the issues in that case, and rested upon no authority. Moreover, the court in *Dodd* ultimately avoided any issue as to the availability of a state law action by correctly holding that "employers" under ERISA—at least employers who gained that status as corporate owners—can be "participants" as employees of the corporation, thereby allowing maintenance of a benefit action under ERISA. *Dodd*, 688 F. Supp. at 571.

under state law rather than as "participants" or "beneficiaries" under ERISA, conflicts with established principles recognized in ERISA case law. The inconsistency created by this decision in implementing an important federal law provides ample grounds upon which to accept review of this case.

C. The Sixth Circuit's Decision Contravenes Clearly Expressed Congressional Intent, Creating Disruption, Confusion, and Unnecessary Expense in the Implementation of ERISA

The decision below is worthy of certiorari not only because it misconstrues Department of Labor regulations and conflicts with other circuit law, but also because of its inconsistency with the clear congressional intent underlying ERISA preemption and its far-reaching impact.

In passing ERISA, Congress expressly found that "the operational scope and economic impact of [employee benefit] plans is increasingly interstate." ERISA § 2(a), 29 U.S.C. § 1001(a). Thus, it was imperative that the uniform federal standards of ERISA become the exclusive law governing employee benefit plans, in order to "eliminat[e] the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent) (quoted in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983)); 120 Cong. Rec. 29,933 (1974) (statement of Sen. Williams) (quoted in *Shaw*, 463 U.S. at 99).

This complete displacement of state regulation was so important that one congressman labeled it the "crowning achievement" of ERISA. 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent) (quoted in

Shaw, 463 U.S. at 99). Moreover, in no less than ten cases over the past decade, this Court has clarified the broad range of ERISA preemption and emphasized its paramount importance.[12] Thus, with "very limited exceptions," *Shaw*, 463 U.S. at 104, none of which apply in this case,[13] ERISA broadly preempts "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan [governed by ERISA]." ERISA § 514(a), 29 U.S.C. § 1144(a) (emphasis added).[14]

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[12] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990); *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478 (1990). The Court heard argument in yet another ERISA preemption case earlier this month. *District of Columbia v. Greater Washington Board of Trade*, No. 91-1326 (U.S. argued Nov. 3, 1992).

[13] ERISA saves from preemption all state laws regulating insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), so long as the state law does not deem an employee benefit plan to be insurance for purposes of state regulation, ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). However, the Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), concluding that state law actions alleging bad faith in processing claims under employee benefit plans are not insurance laws for purposes of this preemption exception, disposes of any contention that the bad faith claims in this case are saved from preemption by the insurance savings clause.

[14] This Court has repeatedly emphasized the sweeping scope of the words "relate to" in ERISA's preemption provision. *E.g.*, *Shaw*, 463 U.S. at 96 ("The breadth of § 514(a)'s reach is ap-

It is impossible to imagine a state law more clearly "relate[d] to" ERISA-governed employee benefit plans than a law governing the processing of plan benefit claims by individuals actually participating in and receiving benefits from an ERISA plan. For example, in *Pilot Life*, this Court had no difficulty finding preemption with respect to claims arising from benefit decisions by a health insurance plan essentially identical to the state law claim in this case, stating:

> The common law causes of action raised in [the plaintiff's] complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for preemption under § 514(a).

Pilot Life, 481 U.S. at 48; *see also Alessi*, 451 U.S. at 510 (noting the centrality of benefit matters to ERISA's regulatory purpose and preemptive effect).

The decision below strikes at the very heart of these important principles. Under the doctrine prevailing in other circuits, the conduct of sponsors and administrators of ERISA-covered employee benefit

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parent from that section's language"); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (describing the "broad scope of [ERISA's] preemption clause" derived from the "broad common-sense meaning" of the phrase "relate to"); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) ("[T]he express preemption provisions of ERISA are deliberately expansive."); *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990) ("The preemption clause is conspicuous for its breadth."); *see also Morales v. TransWorld Airlines, Inc.*, 111 S. Ct. 2031, 2037 (1992) (noting, in a different context, that the "ordinary meaning" of the phrase "relate to" is quite broad, and thus "express[es] a broad preemptive purpose").

plans is governed by ERISA standards. In the Sixth Circuit, however, ERISA-covered employee benefit plans covering both employers and employees will no longer have the benefit of ERISA's "exclusive federal regulation," but rather will be subject to simultaneous regulation under state law.[15]

Indeed, the Sixth Circuit's decision compounds the difficulties that prompted Congress to pass ERISA. While Congress found the existence of "conflicting and inconsistent" state laws to be unacceptable, the holding below assures that benefit plans will be subject not only to ERISA standards, but also to all state laws. Thus, plan administrators in the Sixth Circuit will be caught between potentially conflicting interpretations of identical plan terms depending on whether employers (and state law standards) or employees (and ERISA standards) are at issue. Such a conundrum places administrators in the untenable position of having to vary plan interpretations depending on the identity of the claimant, creating a failure of "uniform construction" that itself may violate ERISA's fiduciary standards. *See, e.g., Wildbur v. Arco Chemical Co.*, 974 F.2d 631, 638 (5th Cir. 1992).[16]

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[15] Such duplicative regulation raises the same concern, expressed in another context in *Darden*, about "the capacity of companies . . . to figure out who their employees are and what, by extension, their pension fund obligations will be." *Darden*, 112 S. Ct. at 1350. This concern applies with special force to the practical need of plan administrators, insurance providers, and self-insured employers to know whether state law claims are cognizable for employer-participants.

[16] Thus, the decision below "could apparently lead to different results for claimants . . . enrolled in identical plans," creating precisely the result this Court found unacceptable in *Darden*.

Nor are the intolerable practical problems of the Sixth Circuit's decision limited to a small number of plans. In fact, the practice of including sole proprietors, partners, or corporate owners in the same plan with employees is commonplace, particularly when the pool of participants is relatively small. According to a recent survey, 69 percent of employees at "small establishments" (those with less than 100 employees) had employer-provided medical coverage; 64 percent had employer-provided life insurance; and 42 percent had an employer-provided retirement plan. U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Small Private Establishments, 1990*, at 1 (1991). Given the size of these enterprises, it is likely that a large portion of these benefits are provided through plans that include both employer and employee participants. Even for larger concerns, where such employer-provided coverage is even more widespread, *see id.* (92 percent receiving health coverage, 94 percent receiving life insurance, and 81 percent participating in a retirement plan), it is not unreasonable to expect a significant number of mixed employer-employee plans.

The practice of encompassing employers and employees in a single plan is encouraged by the structure of group insurance rates and other economies of scale, which make it desirable that health plans and other employee benefit plans cover as many individuals as possible. Few enterprises—particularly small businesses—would find it economical to maintain separate

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112 S. Ct. at 1350. Indeed, the possibility of differing results from the opinion below is far greater than in *Darden*, because the Sixth Circuit's opinion applies two divergent standards rather than one standard that is arguably vague.

health insurance plans for their owners and for other employees. Rather, as in this case, both administrative convenience and economics dictate coverage by a single plan.

While the problems created by the Sixth Circuit's opinion could be avoided, at least prospectively, if all employers separated entirely their own benefit coverage from that of their employees, such a result is squarely inconsistent with the concepts underlying ERISA and would be neither desirable nor practical. This bifurcation of coverage would increase employer costs enormously, since it not only would destroy the benefits of group coverage for business owners but also would double each employer's administrative burden. These vast cost increases, added to current benefit costs that employers already find nearly intolerable, *see* U.S. Small Business Administration, Office of the Chief Counsel for Advocacy, *Focus on the Future: Small Business in the 1990s*, at 27 (1990) (noting the current inability of many small employers to afford health coverage for their employees), would create strong incentives for employers to withdraw health coverage for their employees.

Thus, if the Sixth Circuit's decision is allowed to stand, and particularly if it is followed in other judicial circuits, it will have a widespread impact that will eviscerate the important preemption provisions enacted by Congress and repeatedly sustained by this Court. Accordingly, the importance and scope of the issues at stake, as well as the confusion and inconsistency created by the split between the decision below and jurisprudence in other circuits, demand review by this Court.

CONCLUSION

For the foregoing reasons, the petition should be granted and this case set for plenary consideration.

November 23, 1992

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APPENDIX

APPENDIX A
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 91-3652

Richard FUGARINO, Jo Marie Fugarino and Marc A. Fugarino,

Plaintiffs-Appellants,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY and Consolidated Group, Inc.,

Defendants-Appellees.

Argued June 9, 1992.
Decided July 8, 1992.

Rehearing and Rehearing En Banc
Denied Aug. 24, 1992.

Walter R. Lawrence (argued and briefed), Tallmadge, Ohio, for plaintiffs-appellants.

Lisa M. Newmark, Eliott R. Good (briefed), Philip F. Brown (argued), Chorpenning, Good & Mancuso, Columbus, Ohio, for defendant-appellee.

Before: MARTIN and MILBURN, Circuit Judges; and BROWN, Senior Circuit Judge.

MILBURN, Circuit Judge.

Plaintiffs Richard Fugarino, Jo Marie Fugarino, and Marc A. Fugarino appeal the district court's dismissal of their complaint, which asserted various state law causes

of action relating to an insurance policy purchased from defendant Hartford Life and Accident Insurance Company. The dismissal was under Federal Rule of Civil Procedure 12(b)(6) and based on the ground of preemption pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. On appeal, the principal issues presented are: (1) whether the insurance plan in question is an employee welfare benefit plan as defined by ERISA, (2) whether the status of plaintiff Richard Fugarino as a self-employed sole proprietor affects the status of the insurance plan pursuant to ERISA, (3) whether the district court erred in dismissing the complaint pursuant to Rule 12(b)(6), and (4) whether the district court's Rule 12(b)(6) dismissal is a grant of summary judgment pursuant to Federal Rule of Civil Procedure 52 because the court considered matters outside the pleadings when deciding the motion for dismissal. For the reasons that follow, we affirm in part, reverse in part, and remand.

I.

A.

This case involves a dispute between the plaintiffs and defendants concerning an insurance policy. The policy is a Group Health Insurance Policy which, as stated, was purchased by plaintiff Richard Fugarino from defendant Hartford Life and Accident Insurance Company. The policy is administered by defendant Consolidated Group Inc.

Plaintiff Richard Fugarino purchased the policy to provide health and medical coverage for himself, his dependents, and for a few of his employees and their dependents. Plaintiff Richard Fugarino is the sole proprietor and operator of a business known as "The Glens Restaurant." Full-time and part-time employees work at the restaurant.

The insurance policy was purchased in November of 1985. Since the policy was purchased, three of Richard Fugarino's restaurant employees have been covered under

the policy. Richard Fugarino advised his employees of the insurance program, and they then decided whether or not they wanted to participate in the coverage. The employees who participated in the coverage paid their own premiums by reimbursing Fugarino. However, Fugarino paid for the coverage of one of his employees, and he paid for coverage for his dependents, plaintiff Jo Marie Fugarino, his wife, and plaintiff Marc A. Fugarino, his minor son. The insurance contract was cancelled in June 1989.

On or about February 1, 1988, plaintiff Marc A. Fugarino was involved in an automobile accident. Marc A. Fugarino, who was 17 years of age at the time of the accident, sustained severe injuries which left him a paraplegic. Plaintiffs submitted a claim to defendants for payment of Marc A. Fugarino's expenses arising out of the automobile accident; however, a dispute arose between the parties concerning payment of the expenses.

B.

On February 10, 1989, plaintiffs brought an action against defendants in the Court of Common Pleas of Summit County, Ohio. Plaintiffs' complaint contained four separate counts. Count One sought judgment against defendants for the amount of Marc A. Fugarino's unpaid medical bills arising out of the automobile accident. Count Two sought judgment for unpaid medical bills incurred by some of plaintiff Richard Fugarino's employees. Counts One and Two were subsequently dismissed by agreement of the parties on November 2, 1989, after a settlement was reached by the parties and as well by the plaintiffs in behalf of the restaurant employees.[1]

[1] At oral argument, counsel for the defendants conceded that the settlement did not cover future medical expenses incurred in behalf of Marc A. Fugarino as a result of his automobile accident on February 1, 1988.

Count Three of the complaint sought compensatory and punitive damages for alleged bad faith by defendants in their handling of the claims submitted by plaintiffs on their own behalf and on behalf of the restaurant employees. Count Four sought a declaratory judgment that the insurance contract was in full force and effect and that defendants were responsible for payment of all past and future medical bills incurred by plaintiffs which were covered under defendant Hartford's insurance policy.

On March 20, 1989, defendants removed plaintiffs' case to the United States District Court for the Northern District of Ohio pursuant to 28 U.S.C. §§ 1441 and 1446. Thereafter, on April 27, 1989, defendants filed a motion to dismiss the complaint on the ground that plaintiffs' claims arose under Ohio law and, thus, were preempted by ERISA. Defendants further asserted that plaintiffs failed to abide by the administrative remedies provided by ERISA and the insurance policy in question and, therefore, that the action was filed prematurely.

Plaintiffs filed a motion in opposition to defendants' motion to dismiss. In their motion, plaintiffs requested that the case be remanded back to state court pursuant to 28 U.S.C. § 1447(c). On June 4, 1991, the district court dismissed plaintiffs' complaint pursuant to Rule 12(b)(6) for failure to state a claim upon which relief can be granted. This timely appeal followed.

II.

A.

Plaintiffs first challenge the dismissal of their complaint pursuant to Federal Rule of Civil Procedure 12(b)(6). They argue that because the district court considered matters beyond the pleadings in granting the dismissal that the dismissal is in effect a grant of summary judgment under Federal Rule of Civil Procedure 56. Second, plaintiffs also argue that the district court erred when it failed to give

them ten days notice of its intent to grant summary judgment in favor of defendants.

From the record, it appears that the district court did consider matters outside the pleadings in dismissing this case. When matters outside the pleadings are presented to and considered by the court in a Rule 12(b)(6) motion, the motion is treated as a motion for summary judgment. *See Friedman v. United States,* 927 F.2d 259, 261 (6th Cir.1991). When matters outside the pleadings are considered in ruling on a Rule 12(b)(6) motion, the parties must be given a reasonable opportunity to present all material made pertinent to the motion under Rule 56. *Id.*

Plaintiffs essentially argue that because they were not given explicit notice that the district court would rely on matters outside the pleadings, they were not given a reasonable opportunity to respond to such matters. However, the record belies such assertion. In this case, plaintiffs had ample opportunity to respond to defendants' evidence.

Defendants filed their motion to dismiss on April 27, 1989. They filed an additional memorandum with exhibits in September 1989 and an additional supplemental memorandum with exhibits in November 1989. The district court did not act on defendants' motion until June 4, 1991, when it dismissed the case. Thus, although plaintiffs did not receive explicit notice that the district court would consider matters outside the pleadings, they had approximately two years to respond to defendants' evidence.

In *Dayco Corp. v. Goodyear Tire & Rubber Co.,* 523 F.2d 389 (6th Cir.1975), we addressed circumstances comparable to the facts in this case. In *Dayco,* the district court granted summary judgment in favor of the defendant. The plaintiff appealed, arguing that the district court should have given the parties ten days notice before he considered the defendant's Rule 12(b)(6) motion as a motion for summary judgment. The plaintiff argued that it did not have ample time to supplement the record. *Id.* at

392. However, the record revealed that seven weeks elapsed between the service of the Rule 12(b)(6) motion and the entry of judgment. We held that although it would have been a better practice for the district court to give notice of its intention to treat a Rule 12(b)(6) motion as a summary judgment motion, no error was committed under the circumstances present in *Dayco. Id.*

In this case, plaintiffs responded to each of defendants' motions or memoranda. Furthermore, given the amount of time which elapsed between the filing of defendants' Rule 12(b)(6) motion and the dismissal of plaintiffs' case, it can hardly be said that plaintiffs did not have a reasonable time to respond to defendants' evidence. Thus, the district court did not commit error in failing to give notice to the parties that it would consider matters outside the pleadings in dismissing this case.

B.

As noted above, the district court's dismissal of this case is properly treated as a grant of summary judgment in favor of defendants. This court reviews a district court's grant of summary judgment de novo. *See Faughender v. City of North Olmsted, Ohio,* 927 F.2d 909, 911 (6th Cir. 1991). Summary judgment is proper pursuant to Federal Rule of Civil Procedure 56(c) if the record shows that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. *See Canderm Pharmacal, Ltd. v. Elder Pharmaceuticals, Inc.,* 862 F.2d 597, 601 (6th Cir.1988).

C.

Plaintiffs argue that the district court erred in concluding that the group insurance policy purchased by the plaintiff Richard Fuguarino constituted an ERISA plan. ERISA applies to an employee benefits plan if it is established or maintained by an employer or an employee or-

ganization engaged in commerce or in any industry or activity affecting commerce. 29 U.S.C. § 1003(a); *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240 (5th Cir.1990).

Plaintiffs initially argue that ERISA cannot apply in this case because the restaurant operated by Richard Fugarino is not an industry or activity affecting commerce. However, plaintiffs' assertion was effectively answered by the Supreme Court in *Katzenbach v. McClung*, 379 U.S. 294, 85 S.Ct. 377, 13 L.Ed.2d 290 (1964). In *Katzenbach*, the Supreme Court held that although a single, family-owned restaurant located in Birmingham, Alabama, had a trivial relation to interstate commerce, that was not enough to remove it from federal regulation. *Id.*, 379 U.S. at 300-01, 85 S.Ct. at 382. Similarly, in this case, the restaurant may have a trivial or limited connection or impact upon commerce, but that is not enough to exempt it from regulation under ERISA.

D.

Plaintiffs next argue that the mere purchase of the group health insurance policy by plaintiff Richard Fugarino was insufficient to establish an ERISA plan. Title I of ERISA applies to "any employee benefit plan." 29 U.S.C. § 1003(a). An employee benefit plan is defined as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both . . . ." 29 U.S.C. § 1002(3). ERISA describes an "employee welfare benefit plan" as

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or

> benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

29 U.S.C. § 1002(1). Thus, by its express terms, ERISA encompasses welfare plans provided through the purchase of insurance. *See Memorial Hosp.*, 904 F.2d at 240. Moreover, it is a common practice for employers to provide health care benefits to their employees through the purchase of a group health insurance policy from a commercial insurance company. *Id.* (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727, 105 S.Ct. 2380, 2383, 85 L.Ed.2d 728 (1985)).

However, the United States Department of Labor, pursuant to authority granted to it by Congress, has promulgated regulations providing that certain insurance and other benefit plans are excluded from ERISA's coverage. The Department of Labor regulations provide that the term "employee welfare benefit plan"

> shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection the program, other than reasonable compensation, excluding any profit, for administrative ser-

> vices actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j) (1987). Group health insurance plans which meet each of these criteria are excluded from ERISA coverage. *See Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (5th Cir.1991). Moreover, the bare purchase of insurance, without any of the above elements present, does not constitute an ERISA plan, although it may be evidence of the existence of an ERISA plan. *See Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir.1988) (per curiam), *cert. denied*, 492 U.S. 906, 109 S.Ct. 3216, 106 L.Ed.2d 566 (1989) (citing *Donovan v. Dillingham*, 688 F.2d 1367, 1375 (11th Cir. 1982) (en banc)). An employer has not established an ERISA plan if he merely advertises a group insurance plan that has none of the attributes described in 29 C.F.R. § 2510.3-1(j). *Kanne*, 867 F.2d at 492.

In this case, the Department of Labor regulations do not exclude plaintiffs from ERISA's coverage. Fugarino has done far more than purchase a group health insurance policy and advise his employees of its availability. Fugarino pays the premiums for his employees and permits them to reimburse him. Moreover, the record shows that Fugarino pays the health insurance premium for at least one of his employees.

E.

Relying on the case of *Taggart Corp. v. Life and Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir.1980), *cert. denied*, 450 U.S. 1030, 101 S.Ct. 1739, 68 L.Ed.2d 225 (1981), plaintiffs argue that the group health insurance policy in this case does not constitute an ERISA plan. *Taggart*, however, dealt with a multiple employers trust ("MET") which provided group insurance to employers too small to qualify for group rates on their own. The MET in *Taggart* pooled the premiums for a group of small em-

ployers and purchased a group policy for the group. The Fifth Circuit in *Taggart* concluded that the MET was not a statutory employer of an employee organization and, thus, was not within the scope of ERISA coverage. *Id.* at 1210. The court also held that ERISA did not apply to the purchased health insurance where the purchasing employer neither directly nor indirectly owns, controls, administers, or assumes responsibility for the policy or its benefits. *Id.* at 1211.

Subsequent to the Fifth Circuit's decision in *Taggart*, the Eleventh Circuit decided *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir.1982), in which it rejected the Fifth Circuit's reasoning in *Taggart*. In *Donovan* the Eleventh Circuit found that there were five prerequisites to an ERISA employee welfare plan:

> (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Donovan, 688 F.2d 1371. In *Donovan*, the Eleventh Circuit stated that the gist of ERISA's definitions of the terms employer, employee organization, participant, and beneficiary is that a plan, fund, or program falls within the ambit of ERISA only if such plan, fund, or program covers ERISA participants because of their employee status in an employment relationship, and an employer or employee organization is the person that establishes or maintains the plan, fund, or program. *Id.*; 29 C.F.R. § 2510.3-3(b), (c).

The *Donovan* court further stated that at minimum a plan, fund, or program under ERISA implies the existence

of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits. *Donovan,* 688 F.2d at 1372. Moreover, ERISA does not require a formal, written plan. Rather, ERISA reaches any employee benefit plan if it is established or maintained by an employer or an employee organization, or both, who are engaged in any activities or industry affecting commerce. *Id.* To determine if a plan, fund, or program is a reality, a court must determine whether, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. *Id.* at 1373.

Thus, the Eleventh Circuit stated that it agreed with *Taggart* to the extent that it held that ERISA does not regulate purchases of health insurance where there is no welfare plan. However, the Eleventh Circuit stated that it disagreed with *Taggart* to the extent that the holding in that case implied that an employer or employee organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot establish or maintain an employee welfare benefit plan through the purchase of such group health insurance. *Id.* at 1375.

Recently, this court has adopted the reasoning of the Eleventh Circuit in *Donovan. See International Resources, Inc. v. New York Life Ins. Co.,* 950 F.2d 294, 297 (6th Cir.1991), *cert. denied,* ___ U.S. ___, 112 S.Ct. 2941, 119 L.Ed.2d 565 (1992). Thus, the mere fact that plaintiff Richard Fugarino purchased group health insurance from a MET does not preclude ERISA coverage. Moreover, applying the remainder of the *Donovan* analysis to this case, an ERISA plan does exist. From the surrounding circumstances of this case, a reasonable person can ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. Further, it is clear from the record that plaintiff Richard Fugarino, an employer,

has established and maintained a plan, fund, or program for the purpose of providing health benefits to his employees as participants or beneficiaries of the plan. Therefore, ERISA regulation applies to this case.

F.

Finally, plaintiffs argue that because plaintiff Richard Fugarino is the sole proprietor of a business, the group health insurance he purchased cannot be an ERISA plan. Pursuant to Title I of ERISA,

> . . . the term "employee benefit plan" shall not include any plan, fund or program, . . . under which no employees are participants covered under the plan. . . .

29 C.F.R. § 2510.3-3(b) (19890). The regulations further provide that

> . . . [a]n individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse. . . .

29 C.F.R. § 2510.3-3(c)(1) (1988). As a result of these regulations, a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA. *See Kennedy v. Allied Mut. Ins. Co.*, 952 F.2d 262, 264 (9th Cir.1991). Further, an employer cannot ordinarily be an employee or participant under ERISA. A fundamental requirement of ERISA is that "the assets of a plan shall never inure to the benefit of any employer . . ." 29 U.S.C. § 1103(c)(1). Only "participants" and "beneficiaries" as defined by ERISA have standing to recover benefits under ERISA. 29 U.S.C. § 1132(a)(1). Under ERISA "participant" means

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive

> a benefit of any type from an employee benefit plan. . . .

29 U.S.C. § 1002(7). ERISA defines a "beneficiary" as

> a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

29 U.S.C. § 1002(8). An "employee" and "employer" are plainly meant to be separate entities under ERISA. *See Kwatcher v. Mass. Service Emp. Pension Fund,* 879 F.2d 957, 959 (1st Cir.1989). Thus, a sole proprietor or sole shareholder of a business must be considered an employer and not an employee of the business for purposes of ERISA. *See Kwatcher,* 879 F.2d at 959-60; *Giordano v. Jones,* 867 F.2d 409, 411-12 (7th Cir.1989).

Therefore, neither Richard Fugarino nor his spouse, Jo Marie Fugarino, can qualify as participants in an ERISA plan since Richard Fugarino is the sole proprietor of The Glens Restaurant. Moreover, because their son, Marc A. Fugarino, was covered under the policy based upon his status as their dependent and not as an employee of the restaurant, he is also not a participant or beneficiary under the ERISA plan. Since Richard, Jo Marie, and Marc A. Fugarino are not ERISA participants, the group health insurance policy in this case constitutes an insurance contract governed by state law as to the three of them. In order for an individual to bring an action to recover benefits owed under an ERISA plan, the individual must be a "participant" or "beneficiary" of the plan; if the plaintiff is not a "participant" or "beneficiary," he may sue under and seek the broader relief provided by state tort law. *See Dodd v. John Hancock Mut. Life Ins. Co.,* 688 F.Supp. 564, 568 (E.D.Cal.1988). However, ERISA regulation applies to the employees of The Glens Restaurant who participate in the group health insurance coverage.

G.

Under Ohio law, claims for bad faith dealing in insurance are separate causes of action in tort. *See Hoskins v. Aetna Life Ins. Co.*, 6 Ohio St.3d 272, 452 N.E.2d 1315, 1319 (1983). In this case, plaintiffs have asserted two distinct claims for bad faith dealing—one involving claims for medical expenses for Marc A. Fugarino and one involving claims for medical expenses for certain employees of The Glens Restaurant. Moreover, although plaintiffs settled their claims under Counts One and Two of the complaint, except for Marc A. Fugarino's future medical expenses, they have sought both compensatory and punitive damages under their tort claim in Count Three of their complaint. *See, e.g., AmeriTrust Co. Nat. Ass'n v. West American Ins. Co.*, 37 Ohio App.3d 182, 525 N.E.2d 491, 496 (1987). Thus, plaintiffs' tort claims survive.

Since Marc A. Fugarino is not a participant or beneficiary of the ERISA plan, the claim for bad faith dealing concerning his medical expenses is the subject of Ohio law. Therefore, the district court erred in granting summary judgment for defendants on plaintiffs' claims for bad faith and punitive damages with regard to Marc A. Fugarino under Count Three of their complaint and in not granting plaintiffs' motion for remand of their claims to state court.

With regard to the claims of bad faith dealing and punitive damages concerning the medical expenses of the employees of The Glens Restaurant, the employees are participants and beneficiaries of an ERISA plan. State common law tort claims, such as the employees' claims, are the subject of ERISA preemption. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Therefore, the district court properly granted summary judgment in favor of defendants on these claims.

Plaintiffs' final claim, set forth in Count Four of their complaint, seeks a declaratory judgment that the insurance contract in issue in this case is in full force and effect

and that defendants were responsible for payment of all past, present, and *future* medical bills incurred by plaintiffs covered under the insurance contract. As earlier stated, the parties entered into a settlement of Counts One and Two of their complaint, which involved claims for non-payment of benefits under the insurance contract, but reserved their claim for Marc A. Fugarino's future medical expenses. Therefore, the district court erred in granting summary judgment for defendants with regard to plaintiffs' claim for declaratory relief. However, the employees' claim for declaratory relief under Count IV of the complaint is moot.

III.

For the reasons stated, the district court's grant of summary judgment is AFFIRMED with regard to the claims of the employees of The Glens Restaurant for compensatory and punitive damages for bad faith dealing and with regard to Count Four of plaintiffs' complaint. The district court's grant of summary judgment involving plaintiffs' claim for declaratory relief as to Marc A. Fugarino's future medical expenses and their claims for compensatory and punitive damages for bad faith dealing with regard to Marc A. Fugarino is REVERSED and REMANDED to the district court with instructions to remand those claims to state court.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 91-3652

RICHARD FUGARINO; JO MARIE FUGARINO; MARC A. FUGARINO,
Plaintiffs-Appellants,

v.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY; CONSOLIDATED GROUP, INC.,
Defendants-Appellees.

FILED

Aug. 24, 1992

ORDER

BEFORE: MARTIN and MILBURN, Circuit Judges; and BROWN, Senior Circuit Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green
Leonard Green, Clerk

APPENDIX C

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

CASE NO. 5:89CV0504

RICHARD FUGARINO, et al.,

Plaintiffs,

vs.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY, et al.,

Defendants.

MEMORANDUM AND ORDER

HON. GEORGE W. WHITE

This matter is before the Court on Plaintiffs' motion to remand this case back to the Court of Summit County, Ohio. Defendants have filed a motion in opposition to remand. In addition Defendants have filed a motion to dismiss this action pursuant to Civil Rules of Procedure Rule 12(b)(6), and Plaintiffs have opposed Defendants' motion.

The facts of the case are as follows:

This case involves a dispute over an insurance policy between the Plaintiffs and the Defendants. The insurance contract in question is a Group Health Insurance Policy purchased by Richard Fugarino from defendant Hartford Company, and administered by defendant Consolidated Comany. The plan number was GRH-022003 under policy number A398265. Each separate cause of action arose as a result of how Defendants have handled certain claims submitted to the companies by Plaintiffs.

The insurance policy was purchased by Richard Fugarino, to provides health and medical coverage for himself,

his dependents, and for a few of his employees and their dependents. Plaintiffs Richard Fugarino owns and operates a restaurant called the Glens, and he owns the restaurant as a sole proprietor. He employs both full time and part time employees in the business. At different times since the purchase of the insurance policy in November of 1985, there have been as many as three of his employees who have been covered under this insurance policy.

Richard Fugarino would advertise the insurance program to his employees, and the employees would then decide whether or not they would like to participate in the coverage. The employees that wished to participate, were responsible for payment of their own premium by reimbursing Plaintiff. Only one employee's coverage was paid for by plaintiff Richard Fugarino, and in addition, Richard Fugarino paid for the coverage of himself and his dependents. In June of 1989, the insurance contract was canceled.

Prior to the cancellation of the insurance policy, in February 1988, Marck Fugarino, Richard Fugarino's minor dependent was in an automobile accident and sustained severe injuries that left him a paraplegic. A claim was submitted by the Plaintiffs for the injuries sustained due to the accident, and a dispute arose between the parties with respect to the payment of the claims.

Plaintiff's complaint contains four counts against the Defendants. Count One and Count Two are claims for payments of benefits under the terms of the policy. The causes of action for payments pursuant to Count One and Count Two have been settled between the parties on October 30, 1989, and because of this fact both counts have been dismissed.

In Count Three of Plaintiffs' complaint alleges that defendants Hartford, and Consolidated had a duty to act in good faith and fair dealing in processing and paying claims of the insured. Plaintiffs contend that the

Defendants breached its duty and did not act in good faith, and it is for this reason that Plaintiffs are seeking punitive damages from the Defendants.

The Fourth Count of Plaintiffs' complaint seeks a declaratory judgment finding the insurance contract at issue to be in full force and effect.

This Court is in agreement with the Defendants when they state there are two issues that must be resolved to determine if this case should be remanded back to state court, and those issues are: (1) whether the insurance plan at issue, the multiple employer trust, was governed by ERISA; and (2) whether Plaintiffs were participants in the plan within the meaning of ERISA.

Plaintiffs place much reliance in *Taggart Corporation, et al. v. Life & Health Benefits Administration Inc., et al.*, 617 F.2d 1208 (5th Cir. 1980), in establishing that they were not participants under ERISA. If Plaintiffs prove they were not participants under ERISA, then this case must be remanded back to state court to resolve the remaining issues.

Since this Court is of a different opinion than the *Taggart* court, this Court shall not go into great detail in developing the facts of that case. This Court will only state that the *Taggart* court was dealing with an ERISA issue that involved an employer's sole employee and the employee's wife. The Court found that the Security Multiple Employers Trust (SMET) was a proprietary enterprise, established and operated by independent businessmen for their personal profit. The Court went on to state:

> As a kind of insurance mutual fund, SMET acts as a mere conduit for hundreds of unrelated subscriber customers, forwarding premium payments to a group insurer. Neither Taggart Corporation nor any other employer participates in SMET's day-to-day operation or administration . . . . Such

> an enterprise is neither established nor maintained by the appropriate parties to confer ERISA jurisdiction . . . .

Taggart Corp. v. Life & Health Benefits Administration, 617 F.2d 1208, at 1210 (5th Cir. 1980).

In the present case the dispute arose over claims filed by Plaintiffs under the "Employee Welfare Benefits Plan (EWBP). Plaintiffs contend they were not participants, and Defendants alleges that Plaintiffs were participants of the plan. Plaintiffs contend they only purchased an insurance policy from the Defendants.

ERISA was enacted by the legislature to protect working men and women from abuses in the administration and investment of private retirement plans and employee welfare plans. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 732, 105 S.Ct. 2380, 2385, 85 L.Ed.2d 728, 735-736 (1985).

The purpose of ERISA is defined in 29 U.S.C. Section 1002(1) which reads as follows:

> (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is heretofore established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section

> 186(c) of this title (other than pension retirement or death, and insurance to provide such pensions).

In the present case this Court must determine if the ERISA statutes apply, and if they do apply then this Court will have jurisdiction over this matter, and this case will not be remanded back to state court. If this case does fall under the ERISA statutes then the pre-emptive provision will be pivotal in deciding how this case will be resolved.

The pre-emptive provision of ERISA contains three clauses commonly referred to as the preemptive clause, the saving clause and the deemer clause. The Supreme Court recently described the interrelationship of these provisions as follows:

> If a state law 'relate[s] to . . . employee benefit plan[s]' it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that 'regulat[e] insurance.' § 514(b)(2)(A). The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).

See *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39 (1987).

A specific plan or program will be governed by ERISA if the plan or program covers participants because of their employee status in an employment relationship, and an employer or employee organization is the person that establishes the plan or program. See 29 U.S.C. § 1001, *et seq.*

A court must not look at just one aspect or one element in deciding if a plan or program was intended to qualify as coming under the auspicious of ERISA. A court must look at the totality of a situation in making its determination. In *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), the court asserted the following position:

> In determining whether a plan, fund or program (pursuant to a writing or not) is a reality a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. Some essentials of a plan, fund, or program can be adopted, explicitly or implicitly, from sources outside the plan, fund or program. . . . But no single act in itself necessarily constitutes the establishment of the plan, fund or program. *Id.* at 1373.

The Court is satisfied that Plaintiffs have satisfied the five prerequisites for establishing an ERISA program, and this Court is of the opinion that Plaintiffs were both participants and beneficiaries under ERISA. The five elements are:

> (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982).

This Court does not concur with Plaintiffs' position that they were not a part of an ERISA plan or that they did not maintain the plan for the benefit of their employees. The Glens restaurant began participating in the multiple employer trust in November of 1985, and an administration kit was issued to the employer containing forms and information to be used to administer the plan. The Defendants have supplied to this Court a copy of the bro-

chure that was issued to Plaintiffs that contained the indenture of trust, Article II Section 2, which states the following:

> Each participating Employer shall be the Plan Administrator with respect to each insured welfare benefit plan for its participating employee.
>
> A document containing information specifically about ERISA, and recommendations concerning the preparation of a Summary Plan Description and a Summary Annual Report. The participant employer is identified as the Plan Sponsor and Plan Administrator.

There is no question in this Court's mind Plaintiffs knew they were entering into an ERISA plan, and for several years they were participants of the plan.

In the holding of *Taggart Corporation v. Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), that court found that the Security Multiple Employer Trust which was providing group insurance to employers too small to qualify for group rates on their own, was not itself an employee welfare benefit plan and that Taggart Corporation's subscription to SMET to furnish insurance coverage to Taggart's sole employee did not constitute a plan, fund or program within the meaning of ERISA.

In *Donovan v. Dillingham*, 688 F.2d 1367 at 1375 (11th Cir. 1982) that court in part disagreed with the *Taggart* decision when that court held the following:

> If Taggart is interpreted to mean ERISA does not regulate purchases of health insurance when there is no welfare plan, we agree. The purchase of insurance is only a method of implementing a plan, fund, or program and is evidence of the existence of a plan but is not itself a plan. If Taggart implies that an employer or employee

> organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree. To that extent Taggart shall not longer be binding in the Eleventh Circuit.

This Court is of the same opinion as the *Donovan* court with respect to when an ERISA plan may be said to have been established.

Congress enacted ERISA to protect working men and women from abuses in the administration and investment of private retirement plans and employees welfare plans. ERISA established minimum standards for implementing and carrying out those plans. See *Donovan v. Dillingham*, 688 F.2d 1367 at 1370 (11th Cir. 1982).

In order for an individual to be brought under the umbrella of the ERISA statutes they must be either a participant or a beneficiary of an ERISA plan. If a plaintiff is not a participant or a beneficiary of an ERISA plan, he/she may sue under and seek the broader relief provided by state tort law. *Dodd v. John Hancock Mutual Life Insurance Company*, 688 F.Supp. 564 (E.D. Cal. 1988).

But since this Court has already determined that Plaintiffs were participants under ERISA, this case must come under the jurisdiction of this Court. Furthermore, since the only issues remaining before this Court are not actionable due to the pre-emptive provisions of ERISA, this Court hereby denies Plaintiffs' motion to remand, and dismiss this case pursuant to Civil Rules of Procedure Rule 12(b)(6).

IT IS SO ORDERED.

/s/ George W. White
George W. White 6-4-91
UNITED STATES DISTRICT JUDGE

APPENDIX D

ERISA §§ 3(6)-(8), 29 U.S.C. §§ 1002(6)-(8), provide in full:

> (6) The term "employee" means any individual employed by an employer.
>
> (7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
>
> (8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

ERISA § 514(a), 29 U.S.C. § 1144(a), provides in full:

> Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

APPENDIX E

U.S. Department of Labor

Ms. Susan Katz Hoffman
Pepper, Hamilton & Scheetz
3000 Two Logan Square
Eighteenth & Arch Streets
Philadelphia, Pennsylvania 19103-2799

Dear Ms. Hoffman:

This is in reply to your request for an information letter regarding the applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether title I of ERISA applies to group medical programs which provide medical coverage to a sole proprietor or a partner in an unincorporated business, as well as common law employees, and whether the claims made by such a sole proprietor or partner would be subject to the ERISA claims procedure.

Section 4(a) of title I of ERISA generally provides that any employee benefit plan established or maintained by an employer engaged in commerce or in any industry or activity affecting commerce, by any employee organization representing employees engaged in commerce or in any industry or activity affecting commerce, or by both will be covered by that title unless excluded in subparagraph (b). A program providing medical coverage would generally be considered to be providing benefits among those included in the definition of an employee welfare benefit plan.

The definition of the term "employee benefit plan" contained in section 3(3) of title I of ERISA includes both employee welfare benefit plans and employee pension benefit plans. In regulation 29 CFR 2510.3-3, the Department of Labor (the Department) clarified the definition of the term "employee benefit plan" for the purposes of title I of ERISA. Paragraph (b) of § 2510.3-3 provides that "the term 'employee benefit plan' shall not include any plan, fund or program, other than an apprenticeship or other

training program, under which no employees are participants covered under the plan . . ." For purposes of the regulation, paragraph (c) of § 2510.3-3 provides that certain individuals shall not be deemed to be employees. Specifically § 2510.3-3(c) provides that:

> (c) Employees. For purposes of this section:
>
> (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual and his or her spouse, and
>
> (2) A partner in a partnership and his or her spouse shall not be deemed to employees with respect to the partnership.

If a benefit program were limited to individuals identified in § 2510.3-3(c), the benefit program would not constitute an employee benefit plan described in section 3(3) of title I of ERISA and, therefore, would not be covered by that title. If, on the other hand, the benefit program includes one or more common law employees as well as an individual described in § 2510.3-3(c), such program would be an employee benefit plan within the meaning of section 3(3) of title I of ERISA.

Employee benefit plans covered under title I of ERISA must comply with the claims procedure provisions of section 503 of title I of ERISA and the Department's regulation concerning claims procedures, 29 CFR 2560.503-1. A plan's claims procedure applies to any participant or beneficiary covered under the employee benefit plan, including any participant or beneficiary described in § 2510.3-3(c).

We hope this information will be helpful to you.

Sincerely,

/s/ Robert J. Doyle
ROBERT J. DOYLE
Director of Regulations
and Interpretations

Supreme Court, U.S.
FILED
JAN 22 1993
OFFICE OF THE CLERK

No. 92-893

IN THE

Supreme Court of the United States

October Term, 1992

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY and CONSOLIDATED GROUP, INC.,
Petitioners,

vs.

RICHARD FUGARINO, JO MARIE FUGARINO, and MARC A. FUGARINO,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR RESPONDENTS IN OPPOSITION

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No. 92-893

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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR RESPONDENTS IN OPPOSITION

STATEMENT OF THE CASE

A. Statement of the Facts

The question in this case is whether or not Title I of the Employee Retirement Income Security Act of 1974 ("ERISA" or the "Act"), 29 U.S.C. §§1001, *et seq.*, preempts state law claims brought by and on behalf of a sole proprietor against the insurance company issuing a health insurance policy purchased by the sole proprietor. Respondent, Richard Fugarino owned and operated an

unincorporated business known as "The Glen's Restaurant". This business had always been operated as a sole proprietorship. At no time was the business incorporated.

In 1985, Mr. Fugarino purchased an insurance policy from an independent insurance agent. This policy was issued by Petitioner, The Hartford Life and Accident Insurance Company ("Hartford"), and administered by Petitioner, Consolidated Group, Inc. ("Consolidated"). The policy provided health and medical insurance coverage to Mr. Fugarino, his dependents and some of his restaurant employees.

In February 1988, Mr. Fugarino's seventeen (17) year old son, Marc Fugarino, was involved in a severe automobile accident which left him a paraplegic. In the year following the accident, several disputes arose regarding Marc Fugarino's medical claims which had been submitted for payment pursuant to the terms of the insurance policy. The failure to resolve these disputes lead to the filing of a lawsuit in the Court of Common Pleas, Summit County, Ohio, in 1989.

Respondents sought compensatory and punitive damages for alleged bad faith by the Petitioners in their handling of Marc Fugarino's medical claims and certain of the Respondents' employees. Respondents also sought a declaratory judgment that the insurance contract was in full force and effect; that the Petitioners are responsible for payment of all past and future medical bills incurred by the Respondents and for a determination of their rights under the insurance policy.

Certain Counts contained in the Complaint were subsequently dismissed by agreement of the parties.[1]

On March 20, 1989, Petitioners removed the case to the United States District Court for the Northern District of Ohio pursuant to 28 U.S.C. §§1441 & 1446, claiming exclusive federal jurisdiction under ERISA.

On April 27, 1989, Petitioners filed a Motion to Dismiss Petitioners' Complaint on the grounds that Respondents' claims arise under ERISA and were prematurely filed because Respondents had failed to follow administrative remedies provided under ERISA and the insurance policy itself.

Respondents filed a Motion in Opposition to the Motion to Dismiss, contending that ERISA was not applicable and that all administrative remedies had been exhausted prior to the filing of the Complaint.

On August 3, 1989, Respondents filed a Motion To Remand to state court pursuant to 28 U.S.C. §1447(c). The basis for the Motion To Remand was that no federal question was raised, removal jurisdiction did not exist, ERISA was not applicable and Respondents were not proper parties to bring an ERISA action even if ERISA was applicable.

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[1] Remaining before the Court, were causes of action seeking damages against Petitioners as a result of Petitioners' actions in handling Respondents' claims submitted under the terms of the insurance policy. Furthermore, Respondents' request for a determination of their rights and Petitioners' obligations under the insurance policy was not dismissed. Specifically, Respondents alleged that Petitioners were obligated to cover the tremendous amount of medical bills and expenses expected to be incurred on behalf of Marc Fugarino as a result of the injuries he incurred while the insurance policy was in effect.

B. Decisions of the Courts Below

On June 4, 1991, more than two (2) years after Respondents' Motion to Dismiss was filed, the District Court dismissed the complaint pursuant to Federal Rule of Civil Procedure 12(b)(6) (Pet. App. C at 25a).

The District Court granted Petitioners' motion, not on the grounds that Respondents failed to exhaust administrative remedies as raised in Petitioners' motion, but instead found that Respondents' claims were not actionable due to ERISA pre-emption. In reaching this conclusion, the District Court, relying upon 29 U.S.C. §1001, *et seq.*,[2] stated that two issues must be addressed in order to determine whether or not the case would be remanded back to the state court or resolved in the District Court (Pet. App. C at 22a).

The first issue was whether the insurance contract in question was a plan governed by ERISA. Secondly, the court must determine whether or not Respondents were participants in such plan within the meaning of ERISA (Pet. App. C at 22a). The District Court went on to state that "[i]f Plaintiffs prove that they were not participants under ERISA, then this case must be remanded back to state court to resolve the remaining issues." (Pet. App. C at 20a).

In finding that an ERISA plan had been established, the Court applied the test set out in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (Pet. App. C

[2] The District Court stated that "[a] specific plan or program will be governed by ERISA if the plan or program covers **participants because of their employee status in an employment relationship**, and an employer or employee organization is the person that establishes the plan or program." (Pet. App. C at 22a). Emphasis added.

at 22a-23a). However, the District Court merely took for granted or assumed that the Fugarinos were participants without providing any discussion or basis for its finding.

On appeal, the United States Court of Appeals for the Sixth Circuit agreed with the District Court's finding that the insurance policy purchased by Mr. Fugarino constituted an Employee Welfare Benefit Plan ("EWBP") covered by ERISA, as to his employees (Pet. App. A at 11a).

However, the Sixth Circuit specifically addressed the question, not discussed by the District Court, of whether or not the Fugarinos were "participants" or "beneficiaries" as defined by ERISA. The Sixth Circuit found that Mr. Fugarino and his dependents were not "participants" or "beneficiaries" as those terms are defined by ERISA §3(7)-(8), 29 U.S.C. §1002(7)-(8), and therefore, not an ERISA plan as to Respondents. Thus, they "may sue under and seek the broader relief provided by state tort law" (Pet. App. A at 12a-13a). The case was reversed and remanded to the District Court with instructions to remand Plaintiffs' remaining claims to state court for further proceedings (Pet. App. A at 13a & 15a).

In reaching this conclusion, the Court of Appeals relied upon the plain language of the Act, its express purpose, well established case law, and the class of individuals the Act was designed to protect.

On August 24, 1992, the Sixth Circuit Court denied Petitioners' Petition for Rehearing *en banc*.

REASONS FOR DENYING THE WRIT

The Sixth Circuit's decision is not exceptionable in its construction of those terms contained in ERISA. The decision below applies the well-grounded rules of statutory construction in a consistent, rational, and judicious manner. Petitioner does not contend that the Sixth Circuit failed to follow the well accepted rules of statutory construction, nor that the Sixth Circuit improperly applied these rules. Rather, Petitioner seeks to construe ERISA in a manner which is completely at odds with the intent and purpose of the Act which is to protect employees from employer abuses. An exercise of this Court's certiorari jurisdiction would serve no constructive purpose and should not be granted.

The decision of the Sixth Circuit does not conflict with decisions of this Court and other federal circuit courts of appeal, and therefore, is not worthy of certiorari.

The Court of Appeals decision reflects a clear understanding of the purposes of ERISA and its decision is consistent with the express intent of Congress as set out in the Act. Furthermore, the decision below is consistent with this Court's articulation of that purpose.

Finally, no important federal question is presented that would warrant further consideration by this Court.

A. The Court Below Did Not Err In Determining That Sole Proprietors, Partners, And Corporate Owners Cannot Be "Participants" In ERISA Plans When They Are Covered By Such Plans.

Petitioners first request this Court to revisit a long line of cases which clearly and consistently reiterate the purpose and intent of ERISA. Petitioners challenge to the Sixth Circuit's decision is that the Court misinterpreted the basic provisions of ERISA, misunderstood the purpose of the Act and contravenes Congressional intent in rendering its decision (Pet. at 7).

However, their argument ignores the clear expression of the *intent and purpose* of ERISA, as set out by Congress in 29 U.S.C. §1001 (a) & (c) entitled "Congressional Findings and Declaration of Policy".

Specifically, §1001 states that ERISA was enacted for the protection of "*employees and their beneficiaries*,. . ."; in order to protect "the interests of *participants* in employee benefit plans and *their beneficiaries*, . . ." (App. at _____), 29 U.S.C. §1001(a) & (c) (Emphasis Added).

Furthermore, this Court and other circuit courts of appeal have consistently found that ERISA was enacted for the benefit of *employees and their beneficiaries*. (*See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *Giardono, et al. v. Jones*, 867 F.2d 409 (7th Cir. 1989)).

In *Shaw*, 463 U.S. 85, 90, this Court stated that:

> "Erisa is a comprehensive statute designed to promote the interests of *employees* and *their beneficiaries* in employee benefit plans." (Emphasis added).

See also Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981); *Morash*, 490 U.S. 107.

This exhaustive analysis of the purpose and intent of ERISA by this Court leaves no doubt that ERISA was designed to protect employees and their beneficiaries from employer abuses. Respondents have not found any decision by this Court which determines that ERISA was intended for the protection of employers. The Sixth Circuit's decision is consistent with Congressional intent.

The intent and purpose of ERISA clearly reflects the concerns of Congress in protecting *employees* and *their beneficiaries*, not employers. Moreover, there can be no doubt that, under ERISA, employees and employers are meant to be two different classes of individuals. The definition of beneficiary as one entitled to benefits **because** of his or her relationship to an employee is consistent with the Act and the Sixth Circuit's decision is consistent with that premise.

Acceptance of Petitioners' interpretation of "beneficiary", as used in ERISA, to include an employer is inconsistent with Congressional intent to protect employees from employer abuses. Moreover, the inclusion of an employer in the definition of beneficiary clearly adds a new class of individuals, not provided for by ERISA, who have standing to enforce ERISA remedies. *See Shaw*, 463 U.S. at 90.

Congressional intent, case law, and the provisions of ERISA itself, clearly reflect that the fundamental purpose of ERISA is to protect the interests of employees and their beneficiaries. Clearly, the Sixth Circuit's ruling that a sole proprietor can not be a "beneficiary" is consistent with the express purpose and intent of ERISA, which is to provide *employees*

protection from *employer* abuses. Any other interpretation would not only be inconsistent with the express language of the Act, but would render meaningless Congressional policy declarations as set out in 29 U.S.C. §1001.[3]

Petitioners further suggest that the Sixth Circuit's decision dated July 8, 1992, ignored a Department of Labor opinion letter dated July 31, 1992 (Pet. App. E at 27a-28a, Pet. at 9). While a Department of Labor Opinion Letter can provide guidance to the federal courts, they are not binding. *Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991); *Blessitt v. Retirement Plan for Employees of Dixie Engine Co.*, 848 F.2d 1164, 1167-1168 (11th Cir. 1988).

This Court should not exercise its discretionary jurisdiction because Petitioners feel their definition of *employee* is better, or should be applied, rather than that found in ERISA itself, and in 29 C.F.R. §2510.3-3(c).

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[3] Petitioners' assertion that the Sixth Circuit misapplied 29 C.F.R. 2510.3-3(a) (Pet. at 9-12), is not supported by that Court's decision. The Sixth Circuit specifically addressed the issues Petitioner contends it ignored or erroneously applied in its decision (Pet. App. A at 12a-13a).

B. The Decision Below Is Not At Odds With Prior Decisions Of This Court And Of Other Circuit Courts Of Appeal.

Petitioners' attempt to place the Sixth Circuit's decision at odds with other decisions of this Court and other circuit courts of appeal falls short. Petitioners have failed to cite any decision of these courts inconsistent with the decision of the Sixth Circuit in this case.[4]

On the contrary, there are decisions of this Court that, although do not address the specific issues of this case, would suggest that the Sixth Circuit's decision is consistent with this Court and other Circuit's interpretation of ERISA. *See Nationwide Mutual Insurance Co., et al. v. Darden*, 112 S. Ct. 1344 (1992), where this Court found that an independent contractor was not an employee for purposes of ERISA.[5]

Moreover, several Circuits have held that employers are not participants within the meaning of ERISA and therefore not entitled to bring an action under ERISA. *See Kivatcher v. Massachusetts Service Employees Pension Fund*, 879 F.2d 957 (1st Cir. 1989); *Giardono,*

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[4] Petitioners cite *Harper v. American Chambers Life Insurance Co.*, 898 F.2d 1432 (9th Cir. 1990), in support of their contention that Respondents are beneficiaries under ERISA. However, this case was appealed from the District Court's grant of summary judgment only on the issue of whether or not an ERISA plan had been established. In reversing the District Court's dismissal of the complaint, the Eleventh Circuit stated "[t]he district court apparently decided that as a matter of law the . . . policy was an ERISA plan." *Id.* at 1433.

[5] Respondents do, however, direct this Court's attention to a case out of the Texas Supreme Court, *Forbau v. Aetna Life Insurance Co.*, No. D-1235 (Tex. Nov. 4, 1992) (available on WESTLAW, 1992 WL316493 (Tex.)). However, this case held that a dependent of a corporate shareholder could maintain an action under ERISA as a beneficiary. It did not address the question of whether or not a sole proprietor was a participant or beneficiary under ERISA.

867 F.2d 409; *Peckham v. Board of Trustees*, 653 F.2d 424 (10th Cir. 1981);[6] *Swartz v. Gordon*, 761 F.2d 864 (2d Cir. 1985); *Donovan*, 688 F.2d 1367.

Petitioners' contention that the Court of Appeals' decision in this case will create inconsistency in implementing ERISA is unfounded and unsupported.

Petitioners further contend that:

> "[n]umerous other decisions provide further support for a strict dichotomy between ERISA and non-ERISA plans. With respect to the former, all benefit remedies (including those of employers) are governed by ERISA." (Pet. at 16).

In support of this statement, Petitioners cite *Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991). In this case, the Eleventh Circuit found that an ERISA plan covering only one employee had been established. These cases did not consider whether an employer could pursue ERISA remedies on his own behalf under ERISA. In fact, the Eleventh Circuit found that although only **one** plan had been created, one of the employee's four claims did not concern ERISA benefits and, therefore, must be pursued in state court. *Id.* at 1550.

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[6] Petitioners acknowledge these three cases as holding that employers are not "participants", however, attempts to distinguish them on the basis that they all deal with plans jointly administered by management and Unions, or so-called "Taft-Hartley plans". Thus, Petitioners reason, "the results in these cases *could* be sustained through application of the independent requirements of the LMRA . . ." (Pet. at 15, fn. 9) (Emphasis added). However, Petitioners' contention disregards the plain fact that all of these cases involved pension plans subject to ERISA. Moreover, the respective Courts of Appeal relied upon ERISA in reaching their decisions.

The Appellant in *Williams*, 927 F.2d 1540, was an employee who brought several claims against his employer, some pursuant to ERISA and others under state law. The District Court had dismissed all of Appellant's ERISA claims finding that an ERISA plan had not been established. Appellants state law claims were dismissed based upon various state law doctrines, not ERISA. The Eleventh Circuit found that an ERISA plan had been established and that one of Appellants state law claims was not pre-empted by ERISA. The apparent basis for this is that the particular claim survived ERISA pre-emption because the underlying benefits themselves were not covered by ERISA. Even so, the Court held that only one plan had been established and that Appellant had actionable remedies under that plan pursuant to both ERISA and state law.

C. The Sixth Circuit's Decision Is Consistent With Clearly Expressed Congressional Intent, And Will Not Create Disruption, Confusion, And Unnecessary Expense In The Implementation Of ERISA.

Petitioners contend that the Sixth Circuit's decision will create disruption, confusion and unnecessary expense in the implementation of ERISA. This argument is based upon their contention that the decision will provide different remedies to persons covered under an ERISA plan depending upon whether they are an employee or employer.

However, this contention skirts the Sixth Circuit's decision which found that Respondents' insurance policy, in so far as concerns Respondent and his dependents, did not constitute an ERISA plan. Furthermore, Respondents maintain that the converse is true.

In a situation where a self-employed person purchases a health and medical insurance plan for himself and his beneficiaries only, ERISA will not apply. But, once the employer adds an employee to that very same plan, he loses his ability to seek state law remedies and is confined to ERISA remedies only. Surely this is not what Congress intended when it enacted ERISA. On the contrary, the conversion of an employer's remedies under a health insurance contract subject to state law to an ERISA plan subject to ERISA, merely by including an employee in the plan, will result in more confusion to both state insurance agencies and employers.

Petitioners' attempt to align the Sixth Circuit's decision with the concerns raised by this Court in *Darden*, 112 S. Ct. 1344. However, the concern this Court expressed in *Darden* about the problems an

employer would have in determining who are employees and what pension fund obligations the employer may owe to whom will not result from the Sixth Circuit's decision.

In *Darden*, this Court expressed these concerns in the context of the uncertain test used by the Fourth Circuit in determining whether an individual was an employee or independent contractor. The Fourth Circuit's resolution of that question would turn on the nature and extent of the individual's "reliance" upon his expectation of benefits. No such problems will result from the decision below because the question of whether an individual is an "employee" or "employer" is clear and can be determined without extensive inquiry into subjective and varying facts.

In *Darden*, this Court suggested that normal agency principles should ordinarily be sufficient to determine who is an employee and who is an independent contractor. A similar approach has been taken here. No special rules or tests will be necessary to distinguish who is an employee and who is the employer for purposes of ERISA.

CONCLUSION

Based upon the above, the petition for writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

29 U.S.C. §1001

§1001a. Additional Congressional findings and declaration of policy

(a) Effects of multiemployer pension plans

The Congress finds that—

(1) multiemployer pension plans have a substantial impact on interstate commerce and are affected with a national public interest;

(2) multiemployer pension plans have accounted for a substantial portion of the increase in private pension plan coverage over the past three decades;

(3) the continued well-being and security of millions of employees, retirees, and their dependents are directly affected by multiemployer pension plans; and

(4)(A) withdrawals of contributing employers from a multiemployer pension plan frequently result in substantially increased funding obligations for employers who continue to contribute to the plan, adversely affecting the plan, its participants and beneficiaries, and labor-management relations, and

(B) in a declining industry, the incidence of employer withdrawals is higher and the adverse effects described in subparagraph (A) are exacerbated.

* * *

(c) Policy

It is hereby declared to be the policy of this Act—

(1) to foster and facilitate interstate commerce,

(2) to alleviate certain problems which tend to discourage the maintenance and growth of multiemployer pension plans,

(3) to provide reasonable protection for the interests of participants and beneficiaries of financially distressed multiemployer pension plans, and

(4) to provide a financially self-sufficient program for the guarantee of employer benefits under multiemployer plans.

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JAN 22 1993

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE AN *AMICI CURIAE* BRIEF IN SUPPORT OF PETITIONERS

Pursuant to Supreme Court Rule 37.2, the American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") move for leave to file an *amici curiae* brief in support of the petition for a writ of certiorari filed by Hartford Life and Accident Insurance Company and Consolidated Group, Inc. on November 23, 1992.

ACLI and HIAA obtained the consent of the petitioners to the filing of an *amici curiae* brief, as

indicated by the letter provided to the Clerk's office herewith. Respondents refused to grant consent. Therefore, pursuant to Rule 37.2, ACLI and HIAA need to obtain leave of the Court for filing the accompanying *amici curiae* brief in support of the petition for certiorari.

The Sixth Circuit ruling which is the subject of the petition[1] presents questions (i) whether self-employed individuals may be covered as "participants" or "beneficiaries" under the same ERISA[2] benefit plans as their employees, and (ii) whether such self-employed individuals or their family members may assert claims for benefits under ERISA's exclusive federal scheme (like other employees) or instead under different claims procedures specified by state law.

ACLI and HIAA seek to file a brief as *amici* because of the significant interest they and their members have in the decision below, which conflicts with rulings in other Circuits. ACLI[3] and HIAA[4] are large

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[1] *Fugarino v. Hartford Life and Accident Insurance Co.*, 969 F.2d 178 (6th Cir. 1992).

[2] Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 *et seq.*

[3] ACLI is a trade association representing 611 insurance companies throughout the United States. ACLI members sell approximately 95% of the life insurance policies and about 80% of the health insurance policies currently purchased in the United States from commercial insurers. The vast majority of those health insurance plans are provided to or through employee benefits plans as defined by ERISA.

[4] HIAA is a trade association organized to promote and protect the interests of its members, approximately 260 insurance companies that provide approximately 70% of the fully-insured commercial health insurance in the United States. The vast majority

trade associations, comprised of hundreds of insurers who furnish group health policies covering self-employed individuals, their families, and employees, through employee benefit plans as defined by ERISA. For many of the small firms owned and operated by self-employed individuals, insurance coverage may be available or affordable only through group arrangements offered by insurers like the members of ACLI and HIAA.

The logical consequence of the decision below is to prohibit coverage of self-employed individuals and their families under ERISA-qualified welfare benefit plans. If insurers such as ACLI and HIAA members are prohibited from including these owners in the same insurance policies as those covering their common-law employees, most of the small business owners who presently provide welfare benefit coverage to their employees (as well as themselves) would consider cancelling their coverage, thus potentially exacerbating an already severe crisis of the uninsured.

Furthermore, if the ruling below stands and a conflict in the Circuits persists, the insurer members of ACLI and HIAA will be forced at the minimum to establish separate claims procedures for self-employed individuals and employees receiving benefits under a single employee benefit plan. This would not only increase the insurers' costs, but would ultimately be passed through and significantly increase the cost of group coverage for small businesses owned by self-employed individuals. At a time of rapidly escalating

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of the health insurance policies provided by HIAA members are group insurance policies provided to or through employee benefit plans as defined by ERISA.

health insurance costs, ACLI and HIAA are anxious to avoid legal requirements that impose additional administrative costs.

The accompanying brief does not duplicate the arguments made by petitioners, but focuses instead on the industry-wide perspective of ACLI and HIAA. That perspective should be of assistance to the Court in gauging the significance and impact of the ruling below, and the need for Supreme Court review to clarify the law in this important area in light of the existing conflict in the Circuits.

Conclusion

For the foregoing reasons, the motion for leave to file the accompanying *amici curiae* brief should be granted.

Respectfully submitted,

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QUESTION PRESENTED

Whether self-employed individuals covered under the same ERISA plans as their employees are "participants" or "beneficiaries" in those plans, and therefore are precluded by ERISA's exclusive federal scheme from asserting state law claims for benefits under such plans.

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Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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BRIEF *AMICI CURIAE* OF THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

DESCRIPTION AND INTEREST OF *AMICI CURIAE*[1]

The American Council of Life Insurance ("ACLI") is a trade association representing 611 insurance com-

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[1] *Amici* obtained the consent of the petitioners to filing of this brief; evidence of such consent is on file with the Clerk of the Court pursuant to Rule 37 of this Court. Respondents refused

panies throughout the United States. ACLI members write approximately 95% of the life insurance policies and about 80% of the health insurance policies currently purchased in the United States from commercial insurers. The vast majority of those health insurance policies are provided to or through employee benefit plans as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §§1001 *et seq.*

The Health Insurance Association of America ("HIAA") is a trade association organized to promote and protect the interests of its members, approximately 260 insurance companies that provide approximately 70% of the fully-insured commercial health insurance in the United States. The vast majority of the health insurance policies provided by HIAA members are group insurance policies provided to or through employee benefit plans as defined by ERISA.

The decision below carries significant and adverse implications for the insurer members of ACLI and HIAA, and for the sole proprietorships and partnerships that sponsor insured plans.

First, the logical consequence of the decision is to prohibit coverage of self-employed individuals and their families under ERISA-qualified welfare benefit plans. If owners are thereby prohibited from eligibility under the same insurance policies as those covering the owners' common-law employees, many of the small business owners who presently provide welfare benefit coverage to their employees (as well as to them-

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to grant consent to the filing of this brief, and therefore *Amici* have filed herewith a motion for leave of the Court to file this brief.

selves) would be deprived of a major incentive to sponsor such plans, and would consider cancelling existing coverage, thus potentially exacerbating an already severe national crisis of the uninsured.

Secondly, the decision holds that claims processing for self-employed individuals under an ERISA-qualified welfare plan is not subject to ERISA's civil enforcement scheme. If this is so, insurers will be required to develop and apply separate claims procedures for claims of owners and for claims of employees under a single ERISA plan, thereby undermining ERISA's goal of uniformity, further increasing premiums, and resulting in reduced coverage of employees of small businesses.[2]

Given the importance of these issues to the administration of millions of insured welfare benefit plans, and given the inconsistency in the Circuits regarding interpretation of these issues, *Amici* urge this Court to grant a writ of certiorari to the petitioners.

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[2] *See, e.g.*, HIAA, "A Course in Group Life & Health Insurance" (Fourth Edition 1992), at 150:

> The insurer includes a sufficient amount in the premium rate to meet its anticipated expenses. Typically, the expense formula considers the economies of increasing group size [and] becomes a smaller percentage of premium as the size of the group increases.

Thus, it is the view of the *Amici* that if insurers are required to establish procedures to (1) classify self-employed individuals and their dependents separately under a single policy, and (2) apply state-by-state procedural requirements to their benefit claims that may vary from those required by ERISA, the administrative charges built into premiums for unincorporated businesses will inevitably increase.

SUMMARY OF ARGUMENT

This case involves a medical insurance plan purchased by a self-employed individual for his employees (including himself) and their families. Although the Court below determined that the plan was a welfare benefit plan covered by ERISA and found that he was eligible to receive benefits under the terms of the policy, nevertheless the court found that the self-employed individual was neither a participant nor a beneficiary of the plan, that he could not be covered under an ERISA plan because of ERISA's rule that plan assets may not "inure" to the benefit of an employer, and that claims by his dependents were therefore subject to state law jurisdiction rather than ERISA's civil enforcement scheme.

ERISA contemplates participation of self-employed individuals in certain plans maintained for their employees. Also, a self-employed individual and his or her dependents all satisfy ERISA's definition of "beneficiary" once it has been established that the plan covering them is an ERISA welfare benefit plan because it covers other employees. In administering such plans, insurers must be permitted to treat all beneficiaries of those plans equally regardless of whether they became beneficiaries through common-law employment or self-employment. Therefore, *Amici* urge the Court to grant the requested writ in order to clarify the rights and obligations of all insurers of and self-employed participants in ERISA welfare benefit plans.

The court below erred in construing ERISA's anti-inurement rule to prohibit participation of a self-employed individual in an insured ERISA welfare ben-

efit plan, because the court failed to recognize that when an employer purchases an insurance policy, the only "plan asset" is the policy itself, not the assets of the insurer backing up the policy. Therefore, when the insurer pays benefits to an individual covered by the insurance policy, the benefits are not plan assets, and the anti-inurement rule is not violated.

The Department of Labor, the Second Circuit, and the Ninth Circuit have ruled that self-employed individuals can be participants or beneficiaries in ERISA plans, and that their claims for benefits under those plans are governed exclusively by ERISA's civil enforcement scheme. The First Circuit has held that self-employed individuals cannot be covered under an uninsured ERISA plan, and the Sixth Circuit has now held below that claims by self-employed individuals cannot be brought under ERISA, even when an insured plan is covered by ERISA.

In light of the importance of the issues involved and the serious conflicts among the Circuits involving interpretation of ERISA as applied to plans covering self-employed individuals, the Court should grant the writ of certiorari to petitioners. By doing so, the Court will resolve an important issue under ERISA concerning the ability of insurers to provide benefits to self-employed individuals under insured ERISA welfare benefit plans.

STATEMENT OF THE CASE

Amici adopt the statement of the case as set forth in the petition for certiorari.

ARGUMENT

I. EXCLUSION OF SELF-EMPLOYED INDIVIDUALS FROM ERISA GROUP HEALTH PLANS WILL EXACERBATE THE CRISIS OF THE UNINSURED

Typically the purchasers of small group insurance policies are small businesses, and of these, many are operated as partnerships or sole proprietorships.[3] For these small businesses, insurance coverage may be available or affordable only through group arrangements.[4] The Advisory Council on Social Security and

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[3] One study estimated that:

> there are roughly 4.5 million to 5.5 million businesses in the United States with under 100 employees. Between 1980 and 1986 these firms accounted for over half of all new jobs in the U.S. economy. About half a million new businesses with under 500 employees are formed every year.

Jamison & Retzloff, "Marketing to U.S. Small Businesses in the '90s" (1989). *See also*, Newkirk, *Introduction to Group Insurance*, 3d Edition, at 15 (Dearborn) ("The term 'employees' (those eligible for coverage) may include proprietors and partners, as well as corporate owners who are active in their businesses."). *Amici* estimate that at least half of these small businesses are unincorporated.

[4] In 1990, 81 percent of public and private employees worked for employers that offered health insurance. However, only 27 percent of employers with fewer than 10 employees offered health insurance. Among the larger employers offering health insurance, there is no significant difference between incorporated and unincorporated businesses; over 92% of unincorporated businesses with 25 or more employees offer health benefits to their employees in plans that include the self-employed owners. "Critical Distinctions: How Firms That Offer Health Benefits Differ From Those That Do Not" (Health Insurance Association of America, 1990). Another study found that 40% of sole proprietorships with fewer than 100 employees provide group health

various states addressing the problem of the uninsured have all recognized that availability of affordable insurance coverage to small businesses depends on two things: (i) the ability of insurers to group small businesses into larger purchasing units for the purpose of spreading risk, and (ii) the ability of insurers to rely on ERISA preemption to override state laws that obstruct benefit uniformity, managed care programs, and uniform underwriting standards.[5] To enhance the availability of affordable insurance for self-employed individuals and their employees, insurers must be able to establish national uniformity in claims

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insurance to their employees (in plans that include the self-employed owners), with another 22% providing some other form of group welfare insurance benefit (such as life or disability coverage) in plans that include the self-employed owners. Jamison & Retzloff, *supra*, at 27.

[5] "Commitment to Change: Foundations for Reform," report of the Advisory Council on Social Security (Dec. 19, 1991), *summarized in* 19 BNA Pen. Rep. 4 (Jan. 6, 1992) (proposing model state laws for small business insurance, federal preemption of restrictive state laws, and tax law changes that allow self-employed individuals the same tax treatment for premium payments as common-law employees); BNA Pensions & Benefits Daily (April 7, 1992), report on Massachusetts group marketing program for small businesses; Statements by Senator John H. Chafee, reported by Federal News Service (May 12, 1992) ("40 percent of the nation's uninsured population work for small businesses. . . . Our bill makes health insurance more affordable by reforming . . . insurance market practices that limit small employers. . . . What our proposal does is to establish health insurance purchasing groups, which allow businesses with 100 or fewer employees to pool their employees to spread the risk. . . . [W]e encourage the purchase of health insurance by allowing individuals and the self-employed to deduct 100 percent of the cost of their health insurance premiums.").

processing for small group ERISA welfare plans (as a result of ERISA preemption).

Furthermore, if a self-employed individual cannot cover himself and his family under a plan covering his employees, he has little incentive to provide such benefits to his employees. In addition, the inability of a self-employed individual to be included in the same purchasing group as his employees may well make the insurance unavailable or unaffordable.[6]

II. AN INSURER MUST BE ABLE TO TREAT A SELF-EMPLOYED PERSON AS A PARTICIPANT OR BENEFICIARY UNDER AN ERISA PLAN

The Sixth Circuit found that a self-employed individual cannot pursue an ERISA claim under an ERISA plan because he cannot be a "participant" or a "beneficiary" as defined in ERISA.[7] *Fugarino v. Hartford Life & Accident Ins. Co.*, 969 F.2d 178, 185-86 (6th Cir. 1992). This holding is contrary to the

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[6] Historically, a group insurance policy has been available only to employee groups of ten or more. Watson, *The Elements of Group Insurance*, 55 (1968). Today, a few carriers provide policies to the under-ten employee market. *See also* "Critical Distinctions: How Firms That Offer Health Benefits Differ From Those That Do Not" (Health Insurance Association of America, 1990) at 8 ("[Tax] laws discourage unincorporated owners from providing coverage for themselves and probably for their employees as well").

[7] ERISA defines a "participant" as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan . . . or whose beneficiaries may be eligible to receive any such benefit." ERISA §3(7), 29 U.S.C. §1002(7). ERISA defines a "beneficiary" as "a person designated . . . by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." ERISA §3(8), 29 U.S.C. §1002(8).

plain language of ERISA and to the interpretation of ERISA by the Department of Labor and by other courts. The Sixth Circuit relied on Regulations issued under ERISA providing that ERISA does not cover *a plan* where no common-law employees are participants covered by the plan. *Id.* at 185 (citing 29 C.F.R. §2510.3-3).[8] However, the Department of Labor has consistently opined that self-employed individuals and their families may be covered by ERISA benefit plans when they include common-law employees.[9]

Although this court recently addressed the definition of employment under ERISA, that decision did not address whether a self-employed individual can be covered as a "participant" by a plan that is subject to ERISA because it also covers his common-law employees. *Nationwide Mutual Insurance Co. v. Darden.*[10]

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[8] *See* Petition at 10-12, concerning inapplicability of the Regulations to this issue.

[9] *See, e.g.*, U.S. Department of Labor, Advisory Opinion 79-8A (Jan. 30, 1979) (available on LEXIS) (a multi-employer pension plan could cover a wife of a self-employed individual); Letter from Robert J. Doyle, Director of Regulations and Interpretations, U.S. Department of Labor to Ms. Susan Katz Hoffman, dated July 31, 1992 (App. E to Petitioner's Brief) (a plan covering common-law employees along with a self-employed individual is covered by ERISA, and "a plan's claims procedure applies to any participant or beneficiary covered under the employee benefit plan, including any participant or beneficiary described in [29 C.F.R.] §2510.3-3(c) [self-employed individual]").

[10] 112 S. Ct. 1344, 117 L.Ed. 2d 581 (1992) (this Court held that the term "employee" in ERISA's definition of "participant" is to be interpreted in its traditional common law sense, and therefore, a plan limited to independent contractors was not subject to ERISA).

In fact, ERISA expressly allows for inclusion of self-employed individuals as "participants" in ERISA-covered plans.[11] Similarly, the Internal Revenue Code of 1986 defines self-employed individuals as "employees" in the application of various benefit plan provisions.[12] Thus, a self-employed individual is considered "employed" by himself or by the partnership of which he is a partner (the employer) and can be covered under the plan as a participant pursuant to the terms of the plan and as contemplated by both the Code and ERISA.

Furthermore, any individual who is "designated" by an ERISA plan to receive benefits under the plan may be a "beneficiary" of the plan, even if that individual is not an "employee" under ERISA. A self-employed individual explicitly covered by the terms of an ERISA plan, and his covered dependents, are

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[11] For example, ERISA §403(b)(3)(A) exempts certain custodial accounts from ERISA's trust requirement, where "some or all of the *participants* [of a plan] are employees described in section 401(c)(1) of the Internal Revenue Code of 1986 [i.e., self-employed individuals]." 29 U.S.C. § 1103(b)(3)(A). ERISA §4022(b)(5) indicates that plans sponsored by an unincorporated trade or business are covered by the benefit guarantees of Title IV of ERISA, subject to certain *limitations* (not exclusions) of coverage for "substantial owners" of an unincorporated trade or business, and further indicates that benefits are limited to the extent a "*participant* in a plan . . . is covered by the plan as a substantial owner." 29 U.S.C. § 1322(b)(5)(emphasis added).

[12] *See, e.g.*, 26 U.S.C. §401(c) (tax-qualified retirement plans); §162(l) (medical care insurance); §72(m)(6) (life insurance); §129(e)(3) and (4) (dependent care plans); 26 C.F.R. §1.501(c)(9)-2(a)(1) (tax-exempt welfare trust fund "may include, for example, the proprietor of a business whose employees are members" provided that 90% of the membership are common-law employees).

"persons . . . who may become entitled to a benefit" under the plan, and therefore are beneficiaries of the plan under ERISA.[13] *Harper v. American Chambers Life Insurance Co.*, 898 F.2d 1432, 1434 (9th Cir. 1990) (citing the "plain language" of ERISA).

Other Circuits have held that self-employed individuals may be "participants" or "beneficiaries" in ERISA plans and that their benefit claims are subject to ERISA's claims procedures. *Harper v. American Chambers Life Insurance Co., supra*; *Schwartz v. Gordon*, 761 F.2d 864, 869 (2d Cir. 1985). No Circuit other than the Sixth Circuit, below, has held that a self-employed individual covered by an insured ERISA plan is neither a participant nor a beneficiary in that plan.

The outcome of this disagreement between the Circuits is of crucial significance to the interpretation and application of ERISA by members of the *Amici*. If self-employed individuals are not "participants" in an ERISA-covered benefit plan, the claims procedure requirements of ERISA §503 (29 U.S.C. § 1133) do not apply to those individuals, and insurers must establish separate claims processing units for them that must comply with applicable state law requirements.[14]

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[13] The "beneficiary" definition was not addressed in *Darden* because all of the plan's participants were independent contractors, and a plan is not subject to ERISA if it has no employees.

[14] For example, ERISA plans must satisfy certain maximum time periods for processing of initial claims, for submission of appeals of denied claims, and for review of denied claims. State law requirements may be different. 29 C.F.R. §2560.503-1. Similarly, many state laws set forth notification requirements for termination of coverage under group health and life insurance plans that may be different from those set forth in ERISA. *See*,

Insurers must prepare annual report filings under ERISA by identifying those covered individuals who are "participants." The Pension Benefit Guaranty Corporation has been providing guaranteed benefits to self-employed individuals and those plan sponsors are paying premiums for such guarantees. Therefore, this Court should grant the writ of certiorari for the purpose of clarifying the rights and obligations of millions of unincorporated ERISA plan sponsors.

III. COVERAGE OF A SELF-EMPLOYED INDIVIDUAL UNDER AN ERISA PLAN DOES NOT CONSTITUTE UNLAWFUL INUREMENT

The court below relied upon *Kwatcher v. Massachusetts Service Employees Pension Fund*, 879 F.2d 957 (1st Cir. 1989), for the proposition that a self-employed individual may not be a participant in an ERISA plan because it would violate the "anti-inurement" provision of ERISA Section 403(c)(1), 29 U.S.C. §1103(c)(1).[15] *Fugarino*, 969 F.2d at 186. By applying this rule to an insured plan, the Sixth Circuit created severe legal and administrative concerns for insurers providing benefits to self-employed individuals under insured ERISA welfare benefit plans.[16]

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e.g., *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990) (notice requirement in state law is preempted because of different ERISA notice requirements that apply nationwide).

[15] The ruling in *Kwatcher*, now adopted by the Sixth Circuit below, is directly contradicted by the rulings in *Giardono v. Jones*, 867 F.2d 409 (7th Cir. 1989), and *Peckham v. Board of Trustees*, 719 F.2d 1063, *modified*, 724 F.2d 100 (10th Cir. 1983), and by the Department of Labor opinion letters cited at note 9, *supra*.

[16] The *Kwatcher* decision did not directly affect insurers, because it dealt with an uninsured multiemployer pension trust,

If the anti-inurement rule is violated by a plan fiduciary, the fiduciary may be sued by any plan participant on behalf of the plan for assets wrongfully transferred to the employer. If the payment of insured benefits to a self-employed individual or his family members under an insured plan is a violation of the anti-inurement rule, then insurers must exclude self-employed individuals (this presupposes that payment of such insurance benefits from the general assets of the insurer could constitute payment of plan assets to the employer).[17] However, the Sixth Circuit clearly did not intend to imply that the insurer was prohibited from paying benefits to Mr. Fugarino and his family under his insurance policy.

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and the outcome was consistent with decisions under the exclusive benefit provisions of the Labor Management Relations Act (even though the ERISA rationale was erroneous). The LMRA definition of "employees" is narrower than the definition in ERISA. *Chase v. Trustees of Western Conference of Teamsters Pension Fund*, 753 F.2d 744, 750 (9th Cir. 1985); *Martin v. Hamill*, 608 F.2d 725, 729 (7th Cir. 1979); *Aitken v. IP&GCU Employer Retirement Fund*, 604 F.2d 1261 (9th Cir. 1979).

[17] Since the enactment of ERISA, the Department of Labor has consistently opined that "if an insurance company issues a contract or policy of insurance to a plan and places the consideration for such contract or policy in its general asset account, the assets in such account shall not be considered to be plan assets." 29 C.F.R. §2509.75-2(b) (codifying an interpretive bulletin first issued on February 6, 1975). *Accord, Mack Boring and Parts v. Meeker Sharkey Moffitt*, 930 F.2d 267 (3d Cir. 1991), and cases cited therein. Those cases that have held to the contrary have limited their holdings to situations where the insurer's return on its assets directly affects the return realized by the plan. *Harris Trust & Savings Bank v. John Hancock Mutual Life Ins. Co.*, 970 F.2d 1138 (2d Cir. 1992); *Peoria Union Stock Yards Co. Retirement Plan v. Penn Mutual Life Ins. Co.*, 698 F.2d 320 (7th Cir. 1983).

The error below arose from the court's characterization of insurance benefits as "plan assets." The court failed to recognize that when an employer purchases an insurance policy, the only "plan asset" is the policy itself, not the assets of the insurer backing up the policy. Therefore, when the insurer pays benefits to an individual covered by the insurance policy, the benefits are not plan assets, and the anti-inurement rule is not violated.

The logical consequence of the decision below is that insurers could violate the fiduciary liability provisions of ERISA by providing insurance benefits to self-employed individuals under the same policies of insurance as those covering common law employees. If the insurers could no longer do so, the structure and pricing of the small group insurance market would be severely disrupted.

Since many insurers develop their claims administration and policy design on a national basis, it would be difficult, and certainly costly to consumers, to maintain separate structures for unincorporated employers within the First and Sixth Circuits, and unified structures elsewhere. Therefore, *Amici* urge the Court to grant the requested writ of certiorari to resolve this conflict and to clarify an important issue under ERISA as it applies to coverage of self-employed persons under group insurance arrangements.

CONCLUSION

ACLI and HIAA respectfully request the Court to grant a writ of certiorari to petitioners, for the reasons stated herein.

Respectfully submitted,

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No. 92-893

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY and CONSOLIDATED GROUP, INC.,

Petitioners,

v.

RICHARD FUGARINO, JO MARIE FUGARINO, and MARC A. FUGARINO,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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REPLY MEMORANDUM

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REPLY MEMORANDUM

1. The respondents' primary argument is that the decision below is consistent with congressional intent because the Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to promote only the interests of "employees and their beneficiaries." Brief for Respondents in Opposition ("Opposition") at 7-9.[1] According to respondents, they "have not found any decision by this Court which determines that ERISA was intended for the protection of employers." *Id.* at 8.

The respondents raise a straw man. The policy implicated by the Sixth Circuit's decision is not whether ERISA protects employers; rather, it is Congress' undeniable intent, in order to protect employees, that employee benefit plans be governed exclusively by one uniform standard—ERISA. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1974). While increased administrative burdens from simultaneous compliance with varying state and federal requirements obviously would disadvantage plan sponsors, Congress enacted ERISA preemption because it also benefits employees. If the dual regulation of ERISA plans sanctioned by the decision below is allowed to undermine ERISA's broad preemptive sweep, then all

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[1] In support of this notion, respondents cite, and reproduce in their appendix, 29 U.S.C. § 1001a. That provision describes congressional intent as it relates to "multiemployer pension plans." *Id.*; Opposition, App. at A1-A2. The ERISA plan in this case, however, is neither a "multiemployer" plan nor a "pension" plan; it is a welfare plan sponsored by a single employer. *See* Petition for Writ of Certiorari ("Petition"), App. at 7a-9a (opinion below).

participants and beneficiaries will suffer because, among other things, the resulting administrative burden and expense will create pressures to increase employee costs, reduce benefits or eliminate benefit plan coverage entirely. *See* Petition at 18-23.

2. The respondents also contend that the decision below does not create a split in the lower courts. Opposition at 10-12. However, respondents' attempt, in two footnotes, to distinguish the two primary decisions cited by the petitioners as conflicting with the holding below are unavailing.

Respondents insist that *Forbau v. Aetna Life Insurance Co.*, No. D-1235 (Tex. Nov. 4, 1992),[2] involved a "corporate shareholder"[3] rather than a sole proprietor, and therefore is distinguishable from, rather than inconsistent with, the opinion below. Opposition at 10 n.5. Respondents, however, have raised a distinction without a difference. The rationale of the court below rests on 29 C.F.R. § 2510.3-3(b), which encompasses any "individual who wholly owns a trade or business (*incorporated or unincorporated*)." *Id.*; *see* Petition, App. at 12a (opinion below) (emphasis added). Thus, for ERISA purposes, Forbau, the sole owner of a corporation, is no different than Fugarino, the sole proprietor of an unincorporated business. Under the Sixth Circuit's decision, both corporate owners

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[2] Since the Petition was filed, *Forbau* has been published at 16 Employee Benefits Cas. (BNA) 1007.

[3] Although the Opposition refers to the plan participant in *Forbau* as a "corporate shareholder," he in fact was the sole owner and operator of a grocery store corporation that purchased ERISA medical coverage. *See* 16 Employee Benefits Cas. (BNA) at 1008.

and sole proprietors are equally ineligible for participant status—a holding fundamentally at odds with the Texas Supreme Court's decision in *Forbau* allowing such parties to assert ERISA claims.[4]

The respondents also suggest that *Harper v. American Chambers Life Insurance Co.*, 898 F.2d 1432 (9th Cir. 1990), does not establish a circuit split because the only issue before the court was whether the plan at issue was an ERISA plan. Opposition at 10 n.4. However, contrary to the respondents' assertion, two issues were presented in *Harper*: first, whether an ERISA plan was established; and second, whether the presence of an ERISA plan triggered preemption of all state law benefit claims. *See Harper*, 898 F.2d at 1433. It is the court's holding on this second issue—that ERISA coverage triggers preemption of all state law benefit claims, including claims asserted by partners (a third type of business owner encompassed by the rationale of the court below)—that creates the split relied upon by the petitioners in this case.[5]

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[4] Inexplicably, in an apparent reference to the Sixth Circuit's interpretation of 29 C.F.R. § 2510.3-3(b), the respondents suggest that the petitioners agree with the court's construction of that regulation. Opposition at 6. The respondents are mistaken. As explained in the first section of the Petition, which the respondents' Opposition does not address, the Sixth Circuit fundamentally misconstrued and misapplied this regulation. Petition at 7-12. The Sixth Circuit also ignored the Department of Labor's correct construction of this regulation, to which this Court should defer under *Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). *See* Petition at 9.

[5] The respondents deal at length with a secondary case cited by the petitioners, *Williams v. Wright*, 927 F.2d 1540 (11th Cir. 1991), arguing that the Eleventh Circuit held that *one* plan was created, but that claims for non-ERISA benefits under this plan

3. The respondents finally take issue with two of the many disruptive consequences of the Sixth Circuit's decision described in the Petition. First, the respondents argue that a rule denying state law remedies to employers once employees are added as plan participants contravenes congressional intent by creating "more confusion to both state insurance agencies and employers." Opposition at 13. Second, the respondents deny that a system of simultaneous state and federal regulation will create confusion and chaos for plan administrators, as suggested by this Court in *Nationwide Mutual Insurance Co. v. Darden*, 112 S. Ct. 1344 (1992), because it is easy to determine whether an individual is an "employer" or an "employee." Opposition at 13-14.

With respect to the first argument, the loss of parallel state law remedies is precisely the result intended by Congress whenever an ERISA plan is created. *See, e.g., Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). ERISA preemption would ring hollow, and confusion would be the order of the day, if employers covered under the same ERISA plans as their employees were given state law remedies while their employees were restricted to federal law. The only result consistent with Congress' broad

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could be pursued under state law. Opposition at 11-12. This characterization of *Williams* is inaccurate. In contrast to this case, which involves claims under a single ERISA-covered health insurance policy, *Williams* involved simultaneous claims for "retirement" benefits under an ERISA-covered pension plan, medical benefits under an ERISA-covered welfare plan, and fringe benefits such as country club dues and a company car under non-ERISA plans. *See* 927 F.2d at 1543 & nn. 4-6, 1550.

preemptive intent is for *all* benefit claims under ERISA plans to be governed exclusively by ERISA, regardless of how the plan becomes subject to ERISA or who asserts the claim.[6]

The respondents' final argument concerning *Darden* misapprehends the nature of the confusion created by the decision below. That confusion does not primarily result from difficulty in distinguishing between employers and employees, although that too would surely create confusing litigation in many cases.[7] Rather, the Sixth Circuit's decision creates confusion primarily because it interjects fifty varying state law standards, applicable to all benefit claims asserted by employers, into a benefit structure that heretofore was governed exclusively by ERISA. If plan sponsors and administrators are required to untangle a web of confusing

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[6] Indeed, the employer in this case, like many other small business owners, took affirmative actions to establish an ERISA plan: he submitted a signed enrollment card, identical to the ones submitted by his employees, stating that he was participating in an ERISA plan, and he specifically arranged to add certain of his employees as plan participants. This affirmative election of ERISA coverage, in lieu of an individual insurance policy restricted to Fugarino and his dependents, was advantageous to Fugarino, since, among other things, it allowed him to obtain the significantly lower rates available for group coverage including his employees. The voluntary decision of Fugarino—or any business owner—to obtain the advantages of ERISA coverage triggers all of ERISA's provisions, including ERISA preemption.

[7] As this Court noted in *Darden*, the common law test for identifying employer-employee relationships contains "no shorthand formula or magic phrase that can be applied to find the answer"; rather, it requires assessment of as many as twenty relevant factors, none of which is controlling. 112 S. Ct. at 1348-49.

and contradictory state law regulations in addition to ERISA, the result will be unprecedented confusion and complication—precisely the result that Congress sought to avoid when it enacted ERISA's sweeping preemption provision.

CONCLUSION

For the foregoing reasons, the Petition should be granted and this case set for plenary consideration.

January 27, 1992 Respectfully submitted,

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